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ABSTRACT

A study examined the relationships between teaching, support, supervision, and role modeling in clinical areas in nursing education courses within the context of Britain's Project 2000, an educational reform initiative. The main data sources were semistructured interviews with a total of 53 students, 37 practitioners, and 15 tutors in 3 nurse education centers and case studies conducted in 3 adult branch centers and 3 mental health branch centers. It was widely reported that the helping roles adopted by practitioners and tutorial staff were often understood in different ways, not systematically assigned, and relegated according to competing demands. Most practitioners wanted greater clarification of their different roles, greater familiarity with the Project 2000 curriculum, and training in assessment. Students wanted longer placements and more contact with practitioners. Assessment of students' practice was deemed problematic. Tutorial staff played an insignificant role in assessing practice, and no intentional role modeling was reported. Learning objectives were not always regarded as realistic, and tutors complained that not all practitioners commanded the knowledge necessary for working with the students. Appendixes include the following: tables detailing respondents' responses and characteristics; study timetable; interview schedules/guides; fragment of verbatim transcript of one interview; and observation protocol. Contains 139 references.) (MN)

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ED 390 997

A detailed study of the relationships between teaching, support, supervision and role modelling in clinical areas, within the context of the Project 2000 courses

King's College, London

and

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Research commissioned by the English National Board for Nursing, Midwifery and Health Visiting, London

CE 070 389

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PREFACE

A DETAILED STUDY OF THE RELATIONSHIP BETWEEN TEACHING, SUPPORT, SUPERVISION AND ROLE MODELLING IN CLINICAL AREAS, WITHIN THE CONTEXT OF PROJECT 2000 COURSES

The Board is pleased to publish the report which provides valuable information on the relationship between teaching, support, supervision and role modelling in practice areas, within pre-registration nursing diploma programmes.

Through a variety of means including validation, monitoring and evaluation, the Board ensures that education for practice continues to be relevant both professionally and academically. Research based evidence provides a further important dimension for the development of policy. The findings and recommendations from all the research commissioned by the Board will be considered with a view to confirming or developing the Board's educational policies.

The Board will review its requirements in relation to the roles involved in teaching, supporting and assessing student learning in the practice area.

The research findings in this Final Report relate to the early stages of Project 2000 implementation in three case study centres. This context and some of the limitations of case study approaches will be taken into account in the consideration of the findings in terms of policy development.

Kings College, London

and

University of Manchester

A detailed study of the relationship between teaching, support, supervision and role modelling in clinical areas, within the context of Project 2000 courses.

Research commissioned by the English National Board for Nursing, Midwifery and Health Visiting, London.

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Responsibility for the views expressed, issues of interpretation, questions of inclusion and omission, remain always with the Research Team and do not necessarily reflect the views of the English National Board for Nursing, Midwifery and Health Visiting.

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Linda Hopps, University of London [part]
Peggy Curtis, Department of Health [part]

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The Research Team wish to express sincere thanks to the nameless students, practitioners, tutors and managers in the pilot centres and the main study centres, who made the periods of data collection, in different parts of England, essentially problem free. Given the other demands on their time, which this report will readily acknowledge, their commitment to this research endeavour was considerable. A study of the kind reported here is absolutely dependent on the availability, readiness and candour of informants and guides. The quality of this report is directly owed to them, but its faults lie in the limitations of research method and our partial understanding of a complex, varied and fast changing set of events and issues.

Responsibility for the views expressed, issues of interpretation, questions of inclusion and omission, remain always with the Research Team and do not necessarily reflect the views of the English National Board for Nursing, Midwifery and Health Visiting.

Edward White
Senior Research Fellow
For and on behalf of the Research Team
Summer 1993

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ABBREVIATIONS

ENB	English National Board for Nursing, Midwifery and Health Visiting
CFP	Common Foundation Programme
NFER	National Foundation for Educational Research
NPO	Non-participant observation
P2K	Project 2000
PREPP	Post Registration Education and Practice Project
RGN	Registered General Nurse
RMN	Registered Mental Nurse
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

INTRODUCTION

The significance of clinical learning in the preparation of first level nurses has been acknowledged for many years. However, a literature has accumulated over more than a decade, which has demonstrated the complexity of providing a good learning experience. The role played by practitioners and the environment in which student learning takes place, have both been identified as being particularly significant.

Prior to the introduction of Project 2000 [United Kingdom Central Council 1986], an early experience of which has provided the context for the present study, an apprenticeship model was predominant in nurse education. This model, which required students to meet the demands of service as well as their own educational needs, had received extensive criticism, not only in nursing, but also within other areas of professional education. Thus, as new goals and aspirations have been articulated for nursing practice within new-style arrangements for service provision, it has behoved nurse educationalists to design Project 2000 [P2K] course curricula that fulfil these new requirements.

This has created a new set of major challenges. For example, it has been necessary to make arrangements to prepare students of nursing to work in both institutional and community settings and then to locate appropriate practice settings for students to achieve the learning objectives. Moreover, the demand for collaboration with Institutions of Higher Education, in order to

prepare students for qualification which has both academic and professional currency, has led educationalists to a rethink of not only the theoretical components of the course, but also the practical dimension. In particular, the level of practice to be demonstrated by the student has had to be reconsidered and engaged as part of the new course validation process.

The demands which these changes will make on practitioners, have been recognised both by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting [UKCC] and the English National Board for Nursing, Midwifery and Health Visiting [ENB]. Indeed, the UKCC has clearly acknowledged the need for appropriate preparation for practitioners to fulfil their changed role, while the ENB has developed this aspect further and raised questions about the assignment of appropriate roles and titles for those practitioners involved in student learning. Similarly, the introduction of supernumerary status within P2K, although not a new concept in nurse education, has not generally been applied outside undergraduate programmes. Here, the complexities of the process, particularly in acknowledging the changing needs of students as they progress through the course, have long been acknowledged. So, too, the difficulties of integrating theory and practice have also been previously demonstrated; an experience not unique to nursing. Indeed, attempts in social work and initial teacher training have demonstrated similar features.

These issues confirm the complexity of clinical supervision and

have raised questions about the different roles played by individual practitioners. Thus, although learning through practice is regarded as fundamental to effective professional education and the development of competence in clinical practice, the extent to which this process is currently overcoming the theory/practice gap in Project 2000 nurse education, has remained questionable. It was against such a controversial backdrop that the present study was commissioned and undertaken.

In October 1990, the English National Board for Nursing, Midwifery and Health Visiting [ENB] put out to tender a Project Specification for a two-year research study of the relationships between teaching, support, supervision and role modelling for students in clinical areas within the context of Project 2000 courses.

The ENB believed that teaching, support, supervision and role modelling were all important in the learning process, but was concerned that 'it could not be presumed that the present arrangements were ideal or the most appropriate, or that, for example, mentorship was necessarily the best way to provide elements of support and role modelling'. The ENB wished for the study to provide answers to the issue of the effectiveness of the prevailing circumstance and to indicate whether changes were needed.

The Project Specification required the study to focus on the

latter half of first-wave Project 2000 demonstration courses, to account for the different specialist clinical areas in the Branch Programmes. Moreover, the study was to include attention to:

[a] The inter-relationships of the different roles for the provision of teaching, support, supervision and role modelling;

[b] The merits and demerits of distinguishing the roles in principle and in practice;

[c] The nature and variability of the mentor role in current practice;

[d] Models of good practice for student teaching, support, supervision and role modelling;

[e] Alternative arrangements for more effective teaching, support, supervision and role modelling;

[f] Identification of the personnel who should occupy the roles;

[g] The preparation required for the roles.

The ENB wished, therefore, to commission an empirical study [rather than, say, a theoretical exposition] to address these interests. Accordingly, relevant staff in the Departments of Nursing Studies of the University of Manchester and Kings College, University of London, convened a joint Research Team to develop a collaborative bid which had an empirical orientation, to compete for the offer of research funds.

In order to operationalise the ENB requirements, the Research Team considered it appropriate to design a study which examined the relationships between the different roles which were pre-specified by the ENB, by directing a focus upon individuals who occupied such roles in vivo. Thus, an interest in the

relationship between [say] teaching and supervision, was translated into an empirical examination of the real life relationships between teachers and supervisors.

AIMS

Accordingly, the Research Team agreed the following set of Aims for the present study, which could be accommodated within the time, expertise and budget available:

1. To analyse the concepts of teacher, supporter, mentor and supervisor, both in the literature and as seen by those individuals involved in facilitating clinical learning.
2. To explore the perceptions and interpretations of the value of these roles, by those involved in the Adult and Mental Health Branch Programmes of Project 2000 courses.
3. To make recommendations about the appropriate preparation for practitioners undertaking such roles in the clinical learning environment.

Early into the present investigation, and with the agreement of the Steering Group, the Research Team adopted the following working title; 'An investigation of Project 2000 student learning in clinical areas'. This, because although the relationships between teaching, support, supervision and role modelling for students in clinical areas were initially thought to be central and discrete, they were found to provide an incomplete vista of the issues germane to Project 2000 student learning in practice settings and, therefore, the necessary substance of the study. Accordingly, the following Review of the Literature has intentionally reflected the broader scope adopted by the Research Team and evidence of this orientation will be seen in subsequent sections of the document.

REVIEW OF THE LITERATURE

Project 2000 [UKCC 1986] reported on a number of difficulties which, despite a wealth of empirical work, continued to be unresolved in nurse education. Moreover, members of The Project 2000 Group recognised that the changing political and social context in which nursing care was to be given, meant a new means to prepare practitioners was indicated, to work in a manner demanded by these changes. The challenges that were faced, were;

[i] The educational difficulties of the existing system.

[ii] The problems created within the system for service delivery.

[iii] The demographic changes in the population threatening the existing system.

The evidence identified two major conflicts which threatened the preparation of new practitioners and were of concern in consideration of learning in the practice environment. Firstly, the continued division between theory and practice which Melia [1987] described as part of the 'folklore' of nursing, and secondly the place of the student in clinical areas and the difficulties encountered through their dual roles of worker and learner.

The traditional model of learning practice through apprenticeship had been under examination for many years and was widely regarded as the basis for these difficulties. As early as 1953 the Nuffield Provincial Hospitals Trust raised concern over this as means of adequately preparing students for professional practice

[Alexander 1983]. As a result, they proposed and implemented a scheme now reminiscent of the contemporary Project 2000 training, in Glasgow, Scotland in 1956. The principles of this programme gave students supernumerary status, made the school financially independent of the hospital and framed the whole educational process on the need to link theory with practice; to educate students for practice, rather than by practice.

This scheme addressed the issue of the primacy of practice in nursing education and the inherent conflict between this and nursing theory. Despite a wealth of reports published over the next three decades concerning the need to change the structure and philosophy of nursing education and challenge the traditional relationship between theory and practice, as Alexander [1983] chronicled, the problem remained. It was anticipated that the changes embodied in Project 2000 would offer a solution, however recent works have continued to identify the divergent and often conflicting values of the educational establishment and clinical practice [Holloway and Penson 1987, Jowett et al 1991, Wilson and Startup 1991]. In a recent discussion paper on student learning in clinical areas for the Irish National Board for Nursing, Sloan and Slevin [1991] reiterated the need to integrate theory and practice as a fundamental principle in nursing education; a matter confirmed in importance by the publication of 'Guidelines on reducing the gap between theory and practice' by the Commission of the European Communities [1990] [cited in Sloan and Slevin 1991]. The important notion which underlay these interests

has concerned the nature of nursing knowledge and its traditional relationship to practice.

The relationship between nursing knowledge and nursing practice. Champion [1989] remarked that there was ample evidence to show that nurses learnt their nursing according to practice models [Rauen 1974, Fretwell 1982, Buckenham 1988, Clifford 1992], but much less that their level of education affected practice. Indeed, a comparative study in the substantive area of pre-registration nurse educational programmes has recently been commissioned by the English National Board [While A et al 1991]. Empirical evidence was presented by Alexander [1983], Davis [1984] and Burnard [1988a] which suggested that if students were given theory and then not given the opportunity to practice, they learnt very little. The relevance of theory given in school, to the real world of practice, was called into question by Bendall [1975] and Gott [1984], with evidence to show that students compartmentalise the two, in order to negotiate their way successfully through the course of preparation [Miller 1985]. The use of the medical model, as a basis to teach theoretical nursing, was suggested as one reason for this and Holloway and Penson [1987] further identified that 'student nurses perceive very quickly that the ward is reality and the master teacher, the ward sister, is the most important person to learn from'.

Clarke [1986] and MacCaugherty [1991] both noted the difficulty of teaching something which was not generalisable and

predictable. MacCaugherty [1991] made explicit the importance of 'knowledge by description' to provide a feeling for things that are outside a range of experience. However, these would never be the same as reality, especially in situations where there were so many different processes occurring together. Clarke [1986] suggested that the world of practice was further distanced when these generalisable accounts of the nursing world, became idealised accounts. Moreover, Miller [1985] reported that the people who were involved in teaching nursing were so divorced from the world of practice that they used different vocabularies, had different perceptions of patients and nursing, and valued different forms of knowledge. She suggested that nurses had difficulty reading nursing theory, because it was often jargonised and American, based on abstract and diverse concepts.

She went on to assert that although the term 'theory' was used to differentiate between classroom teaching and ward teaching, it had become more recently a means to describe a set of interrelated ideas about nursing. However, many of these theories had been devised for nursing education and for use as a framework for teaching in the classroom. Learners were expected to use similar approaches in their practice, but had not encountered this in reality.

There had been an expectation for the school to provide the student with theory and then they would apply this in the practice setting; an application model of nursing practice

[Champion 1989]. Champion suggested that this was the basis of the theory/practice gap, since greater value was placed on theoretical knowledge, than that embedded in practice. Since the two were seen to be so far apart, the student was left in a situation of conflict throughout their professional preparation. Binnie [cited in Laurent 1992] suggested the lack of value placed on practice; 'nursing has got to believe in practice, I'm not sure if it does. I think alot of lip service is paid to practice'.

The value of knowledge in practice.

The different forms of knowledge to inform nursing practice have been well documented [for example, Carper 1978, Eraut 1985, Schon 1987]. An essential distinction has been drawn between the scientific paradigm, which considers empirical, technical-rational, or cognitive knowledge and the arts paradigm [Carper 1978, Jarvis 1983, Eraut 1985, Schon 1987]. Fish, Twinn and Purr [1990] drew the distinction between 'knowledge that' [theoretical] and 'knowledge how' [practical], while Clarke [1986] noted that Western culture has, in the past, viewed practical knowledge as essentially inferior to theoretical knowledge. Carper [1978] reflected upon the traditional values in Western culture and asserted that 'one is almost led to believe that the only valid and reliable knowledge is that which is empirical, factual, objectively descriptive and generalisable'. The formal knowledge taught in nursing education has reflected this belief, itself having been traditionally based

on a medical model [Holloway and Penson 1987], as was indicated earlier in this section. Schon [1987] and others who have developed his work, challenged the authority of this as a basis for professional practice.

That it was necessary for research to articulate nursing knowledge and for it then to be used to inform and develop practice, has been raised by several writers [eg Eraut 1985, Miller 1985, Fish and Purr 1991]. However, it has been suggested that the responsibility for this has neither been accepted by the academic, nor practice, communities. Benner [1984] demonstrated that different types of knowledge underpinned the actions of learner [novice] nurses and experts. She forecast that some new nurses would have difficulty in learning from the expert. Too often, she predicted, the experts would have difficulty in making explicit all that was known to the learner. This theme was revisited by Schon [1987] in his description of the 'learning bind' in which students and their supervisors could get into, together with the difficulties of making explicit knowledge embedded in practice.

Models of learning in practice.

Consideration of the distance between theory and practice, has provided some understanding of the difficulties experienced by the student in their dual roles of worker and learner. The importance of the practice setting for students to learn nursing has been established and their role in this environment has

received considerable attention.

Project 2000 altered many of the principles on which the preparation of nurses had been traditionally based. The main structural change, indeed the one which proposed to radically alter learning in practice settings, was the notion of conventional student status. The corollory was that students of nursing would become supernumerary in practical placement areas. Robinson [1991] and Jowett et al [1992] both identified this as a major concern amongst students and practitioners; 'concerns about identifying and putting into practice a working definition of student status [with its implication for policies on attendance and the model of learning followed] were voiced by different groups'. Experience of this as a student role, had previously been confined to undergraduate programmes and exploratory pilot schemes. For example, Collins [1989] reported on the six Project 2000 pilot schemes and noted:

> '....learner nurses, trained staff and teachers have difficulty in clarifying the benefits and otherwise of supernumerary status. They have therefore experienced some conflict in implementing this in practice. Students and staff alike are unsure how supernumerary students fit into the ward team'.

This change in role was to alter the traditional model of learning in practice. The traditional student nurse role had been one of worker and learner and within this the traditional model of learning was one of apprenticeship, based on the assumption that if students were put in a clinical setting, they would learn the skills of nursing as they worked [Marson 1982]. It was a model which had its origins in industry, where the novice learnt

through 'sitting by Nellie' [Jarvis 1983] and disregarded the need for skilled teaching and supervision [Jarvis and Gibson 1985]. Beckett [1984] suggested that such a model provided the advantage of constant supervision, which allowed the linkage of theory to practice.

It has been suggested [Melia 1987] that this model benefitted the system, but not the learners. Holloway and Penson [1987] suggested that on the one hand there was much casual learning, but, on the other hand, there was an inculcation of rituals. This raised problems associated with learning from a role model. The provision of routine tasks, usually within the realms of basic care, as a learning experience, was repeatedly identified as inhibitory in the learning of professional practice [for example Pembrey 1980, Fretwell 1983, Infante 1985, Melia 1987, Fish, Twinn and Purr 1990]. However, that this occupied the majority of the students time in placement areas was consistently noted [Melia 1987, Jacka and Lewin 1987, Mackay 1989]. In response to these observations, Howie [1986] predicted the importance of supernumerary status in 'transforming a situation where, at present, neither the student is free to learn, nor the teacher to teach'. The underlying assumption of the apprenticeship model was that education took place outside the practice setting and was separate from practice. It was based on the application model of nursing practice which, as previously suggested in this review, placed no value on practice knowledge.

Empirical work by Benner [1984] was a landmark which suggested that there was something important to be learnt from practice. An alternative model of learning was proposed by Schon [1987] and this has been studied in practice [Fish, Twinn and Purr 1989 & 1990, Fish and Purr 1991, Brook and Champion 1992]. In his seminal work, Schon [1987] added significantly to the debate about the relationship of theory and practice. His argument for the value of knowledge embedded in practice contributed to the development of a model of learning through practice which recognised the centrality of the practitioner in the educative process. He termed the model of professional knowledge which underlay this approach, one of professional artistry 'to refer to the kinds of competence practitioners sometimes display in unique, uncertain and conflicting situations of practice'.

It has been asserted that nursing involves dynamic and unpredictable situations [MacCaugherty 1991] and Schon referred to these as 'the swampy lowlands of practice'. He challenged the use of the scientific paradigm as a basis for professional practice and argued the limitation of being able only to solve generalisable, predictable and certain happenings through the application of scientific knowledge. Schon suggested a model of reflective practice based on 'reflection-in-action' and the means of learning this within a reflective practicum. A discussion of this approach was presented by Champion and Brook [1992]. They reported empirical work which suggested that the development of such skills in pre-registration education was unlikely. However,

they concluded that reflective practice was a beneficial model of professional practice which provided an effective environment for teaching and learning.

Fish, Twinn and Purr [1989] studied supervision in practice education and, more particularly, how practitioners enabled students to learn in practice. They found considerable confusion and devised a model of supervision based on Schons reflective practice. Further work [Fish, Twinn and Purr 1990] demonstrated the use of this model and suggested a means of using it in professional practice. Fish continued in this area through work for the English National Board to establish how learning took place in continuing professional education [Fish and Purr 1991]. Again she found little evidence of the model of learning proposed by Schon. More fundamentally she reported little understanding of the processes involved in students learning practice and continued evidence of the applicatory view of the relationship between theory and practice, together with a continued poor definition of the role of supervisor. She suggested this reflected a lack of value attached to this role.

The role of practitioners.

The importance of the Ward Sister/Charge Nurse had become almost indisputable within the traditional apprenticeship model of clinical learning. S/he had been recognised for being an important influence in the creation of the right atmosphere in the ward situation to facilitate student learning [Pembrey 1980,

Ogier 1982, Reid 1985a, Jacka and Lewin 1987, Hyland et al 1988] as well as for his/her teaching role. The difficulties of fulfilling this expectation, however, rather than success within it, have more frequently been reported [Fretwell 1980, Redfern 1981]. Marriott [1991] reviewed the literature which concerned teaching in the clinical environment and found that in all but one of the studies reviewed, the sister occupied a key role in creating and controlling the ward learning environment. Importantly, it was not just his/her own commitment to teaching and the amount of teaching undertaken, but tne organisation of the ward work, the leadership style and the patterns of interaction which contributed to this environment. There was evidence that such approaches adopted by the ward sister were reflected in the other staff in the clinical area [Hyland 1988 et al] which sustained the ward atmosphere.

The changing role of the ward sister from someone who was expert in all the care given in the ward, to a manager who guided the actions of others has been recognised [Lamond 1974, Ogier and Barnett 1986, Audit Commission 1991] and with this the increasing importance of the staff nurse as a teacher in the clinical environment [Alexander 1983, Windsor 1987]. Fretwell [1980] and Jacka and Lewin [1987] found evidence that students learnt much of their nursing from their peers. The work by Marson [1982], however, raised questions which concerned whether anyone was teaching students. Just over half of her respondents reported what she termed 'self-initiated, or internal learning, arising

out of the experience rather than someones intention to teach' when asked to describe a recent event that had resulted in significant learning for them.

The notion of available teaching time was raised by the UKCC [1986] in relation to the new supernumerary status of students, although this was already identified as an issue through the demands of service on both practitioners and learners [Howie 1986]. It has also been exposed by community practitioners [Elkan and Robinson 1991, Orr and Hallett 1992] who have been instrumental in the change of emphasis for initial preparation from institutional based care to that given in the community. Similarly, within hospitals, Wilson [1989] reported 79% of her respondents in ward areas identifying inadequate time to supervise supernumerary students.

The passive nature of learning in practice has been identified. Fish and Purr [1991] reported a lack of understanding of the process of learning clinical skills and the need for better preparation in this role. This was supported elsewhere. Recognition of the importance of the Sister [Fretwell 1980] and the Staff nurse [Windsor 1987] to students in clinical areas has been argued to improve practice learning. Similarly, the lack of adequate preparation for practitioners has been highlighted.

Wilson [1989] noted that 50% of her staff nurse respondents had no preparation for teaching. However, that those who taught in

the wards did not recognise their role, produced a situation where it was difficult to establish if learning had taken place [Hyland et al 1988].

The role of Nurse Teachers.

The tutor has had an undisputed role in teaching nursing, yet the history of this role in the clinical environment has not been without difficulties. A full account of the development of the role of the clinical teacher has been provided by Martin [1989]. In essence, the formal role of school representatives in practice settings, reflected the value given to knowledge in practice and the predominant model of learning within the system. Work by Robertson [1987] and Martin [1989] addressed the difficulties experienced by the clinical tutor; a position which arose from the perceived need to provide students with a teacher based in education to help them to apply theory to practice. These studies showed that this role, through being initially adopted as a temporary measure, was never formally confirmed, clarified or evaluated [Robertson 1987]. As a result, the encumbants were subject to ambiguity, strain and conflict; that is, being a guest in the ward area and having secondary status as nurse teachers, rather than nurse tutors [Martin 1989]. Champion [1989] presented a logical argument for the failure of this role in vivo, based around the need for both authority and expertise in practice which [she argued] was not possible in the way the role was structured. Her conclusions argued for the development of lecturer-practitioners who could assume a logical place in

clinical practice. The role of clinical teacher was eventually discontinued as part of a move towards one grade of nurse tutor [Buttigieg 1990].

Payne et al [1991] reported a continuing uncertainty and confusion regarding the extent of nurse teachers responsibilities in clinical areas following the introduction of Project 2000. The system in evidence was reported as one of tutors who linked with clinical areas [Payne et al 1991, Clifford 1992, Crotty 1993]; however, the nature and extent of this role was varied. Nevertheless, there has been continued evidence of the importance of a clinical teaching role in contributing to a positive learning environment [Reid 1985b, Clifford 1992].

The difficulties surrounding the place of educational representatives in clinical areas was identified as rooted in the need for them to be both experts in education and nursing [Champion 1989, MacCaugherty 1991, Clifford 1992]. Crotty [1993] identified clinical credibility as being important to her teacher respondents and this has also been identified as important to students [Morgan and Knox 1987, Nehring 1990]. More often students rated personal characteristics as important in good clinical teachers [Marson 1982, Flagler et al 1988, Smith 1988] and identified the relationship as more important than the opportunities for teaching that occurred [Smith 1988]. This was also identified by Tough [1979]; 'learning can proceed very effectively when guided by the appropriate person interacting

with the learner in a one to one situation' [cited in Shaiman and Inhabler 1985].

For the teacher, time was again identified as a constraint on their role in practice areas [Jones 1985, Payne et al 1991, Clifford 1992, Crotty 1993] and more specifically the conflict of interests raised by curriculum demands, against visits to clinical link areas. In terms of their actual role in practice, this was identified as having changed from one of helping students to learn practice skills [vis a vis the clinical teacher] to that of liaison, support, supervision and communication particularly within the new course. Educational staff, in the studies by Payne et al [1991] and Clifford [1992], identified a role for clinical staff as well as for students. Indeed, that the ward staff had an influence on the frequency of teacher visits, was suggested by the findings that education staff would visit areas more frequently if they had good relationships with the staff and particularly the sister in the ward [Reid 1985a, Clifford 1992].

New roles in the practice environment.

The move from an apprenticeship model of education, which placed little value on knowledge in practice, to one based on learning through practice, combined with the dissolution of any student obligation to service through supernumerary status, has effected a new recognition and importance for the role of practitioners in the teaching of clinical practice. This has precipitated a

renewed examination of the needs of students in clinical settings and attempts have been made to formalise relationships which have been evident in practice teaching and considered beneficial to the learning situation.

Mentors and preceptors.

Historically, a discussion of the terms mentor and preceptor began in the corporate environment in America and their first appearance in nursing was in the late 1970's, although the majority of work in the United Kingdom did not appear until the mid 1980's [Collins and Scott 1978]. This increased interest with roles that support the novice practitioner was associated with the development of Project 2000, which recognised the need for student support and teaching from staff in clinical areas [ENB 1986] and with this the stipulation that first level nurses be available to students to act as supervisors, assessors and if possible mentors [ENB 1989]. The publication of the UKCC's Post Registration Education and Practice Project [PREPP] documents, has also proposed that a newly qualified practitioner should receive a period of support from a preceptor to help them consolidate their nursing practice [UKCC 1990]. Morle [1988] has suggested that the emergence of these supportive roles have arisen from the need to curtail the wastage, particularly from the graduate population, resulting from 'reality shock' [Krammer 1974 cited in Morle 1988].

Empirical studies by Dobbs [1988], Clayton et al [1989] and

Pierce [1991] have all confirmed the use of preceptorship programmes as a means of assisting the student in their role transition. These American studies were added to by the work in the United Kingdom of Foy and Waltho [1989] which, although smaller scale, reported similar findings. Myrick and Awrey [1988] studied the beneficial effects of preceptorship, but chose to measure student performance as rated by students, preceptors and clinical instructors, as the outcome. They found no conclusive evidence to support the use of preceptorship as a clinical teaching strategy. Equally, Allanach and Jennings [1990] evaluated a preceptor programme as a means to ease the transition from student to staff nurse. The method used did not reveal any expressed difficulty during this period. However, the study only used one group of new staff and these were all exposed to the preceptor programme. It was not possible to tell whether the findings were because of the preceptors, or other factors.

The literature on mentorship has also been inconclusive. Merriam [1983] in her comprehensive review across several disciplines for common findings, trends or generalisations, concluded that it was very difficult to work out exactly how important mentors were. She noted studies in which the majority of subjects who had been mentored tended to conclude that mentors led to success, and ignored the successful unmentored, or indeed any other possible explanation for success. She considered the literature on mentoring to be skewed in favour of its worth. A German study of mentors for the students in the Fern Universitat [the equivalent

of the Open University in the UK] examined the outcome of providing mentors as support for students [Fritsch and Srohlein 1988]. They noted the number of contacts students made with their mentors and the number of assignments they completed, and related this to the students academic progress. They found that students who completed more assignments and had mentor support, always did well. The students who did neither, did not do well. The remaining students who did well, either had received mentor support, or had completed more assignments, but there was no difference in the success of these two groups. They were therefore unable to relate student success to mentor support.

Much of the debate has concerned the meanings and use of the different terms; indeed, Hagerty [1986] in a review of the American literature referred to a 'definition quagmire'. Boyes [1989] studied five centres in Scotland to explore the role of preceptor and found seven different terms in use for what she saw as the same role. Burnard [1988b] also noted that the term mentorship 'seems to have slipped into the folklore of nurse education almost unnoticed and quickly became part of the educational language of the eighties and nineties'.

The substantive literature has identified many different functions given to the roles. Shaiman and Inhabler [1985] noted five responsibilities which concerned preceptorship; orientation, socialisation, teaching, observation and evaluation, assisting in the setting of learning objectives and communication with

superiors about the preceptee. They suggested that the preceptor, preceptee, nursing manager and educator all had responsibilities at different phases of the assessment, planning, implementation and evaluation of these functions. They required the following prerequisites from the preceptor; years of experience, leadership skills, communication skills, decision making ability, and interest in professional growth [Shaiman and Inhabler 1985]. Similarly a number of different roles have been reported within preceptorship; rolemodel, teacher, resource [Myrick 1988, Shaiman and Inhabler 1885] and counsellor [Myrick 1988]. Anecdotal accounts of preceptorship in practice have added practitioner [Raichura and Riley 1985], mentor [Lee 1989, The Mental Health Team of North Manchester General Hospital 1989], supervisor and assessor [Lee 1989].

There was no conclusive empirical evidence that preceptorship, or mentorship, in nursing were effective although the number of anecdotal accounts and discussion papers from both sides of the Atlantic recognised the importance which such roles had assumed in nursing. Sloan and Slevin [1991], after a considerable review of the literature on both mentors and preceptors, suggested that the roles were part of a continuum of help required by learners in the clinical setting, at different stages of their development. They suggested that for new learners considerable personal support in the form of mentorship and directive teaching and learning [preceptorship] was of priority. Later, as they required more space, the clinicians role was that of facilitator.

Although they believed role modellng was of importance from the earliest days, as the learner advanced and was able to utilise more cognitive features [Dortan et al 1986], students required a more distant relationship with those from whom they learnt.

Role models.

Within the apprenticeship model, little attention was given to the explicit teaching of clinical practice and Holloway and Penson [1987] identified the importance of rolemodels within this as a means by which nursing skills were learnt. It has been suggested that this was the traditional role for practitioners in teaching students clinical practice and was a very passive form of teaching [Donovan 1990]. 'Role model' has been a term widely used in the literature which concerned the learning of practical skills, but in relation to the practice of mental health nursing it has not been a feature. Bodley [1991] suggested that the practice of mental health nursing was not as obvious as general nursing and, for this reason, she presented an argument for the use of reflective practice in mental health nursing as a means of making explicit the complexity of professional decision making and professional practice.

Raichura and Riley [1985] cited Bandura [1977] in the suggestion that all learning occurs as a result of the observation of models and the more complex the behaviour, the more suited it is to modelling [Wilkinson 1989]. The actual behaviours identified as learnt through rolemodelling were in the affective domain [Dodds

undated, Holloway and Penson 1987, Jarvis 1983, Hill 1989] and could be learnt from anyone, although Shuval and Adler [1980] reported that their students had a tendency to pick and chose selectively of the norms presented to them. Students were able to consider alternative models and to view some clinical teachers encountered as anti-models. More frequently, however, any effective nurse [Rauen 1974] and those identified as teachers, were viewed as role models by students [Jarvis 1983, Clifford 1992]. The importance of this process for students was reported by Marson [1982].

Dortan et al [1986] reported on the different role models important to nurses at different stages of their career. They identified five major stages in a nurse's career when they could be exposed to rolemodels; pre-nursing, basic nursing education, neophyte practice, post-basic studies and established/advanced practice. They found that the most common relationship where role modelling occurred was when the role model was in a senior position; ie, teacher-student, or supervisor-subordinate, and often served as mentors as well. They suggested the need for role models throughout the professional life. However, they identified that the benefits altered as the individual progressed. They reported that generally affective attributes of the model were valued in the earlier stages and cognitive attributes as the recipient became more competent.

Jarvis [1983] and Holloway and Penson [1987] both suggested that

this concept was more suited in a discussion of socialisation, than in consideration as an educative process and the importance of it reflected the model of learning in evidence.'The education system (which is presently in existence) emphasises 'competence', the acquisition of knowledge and skills, rather than 'performance', the use of knowledge and skill in practice. As casual practice learning has been replaced by more formal academic study, abstract models of care and competence are likely to replace personal role models such as the ward sister or the auxillary' [Holloway and Penson 1987].

Supervision.

To understand the change in the nature of supervision in practice, has required an understanding of the change in organisational structure which has accompanied new professional practice, and therefore supported a new preparation for practice. The literature has identified supervision both as a managerial function [Wong and Wong 1987, Merchant 1992] and an educational function [Fish, Twinn and Purr 1990, Butterworth 1992]. Again, the extent of consideration and use of the term was found to vary in the different areas of practice. In general nursing, although role modelling was a process which received consideration, it has been in mental health practice that the term supervision has been more evident. Supervision in mental health nursing, social work or counselling, has had much more of an emphasis on the relationship between the two people concerned and noticeably for the development and support of the

practitioner [Bodley 1991, Ravey 1992].

A renewed importance for supervision in nursing, and specifically in relation to the development of clinical practice, has been reported by recent empirical works from Fish, Twinn and Purr [1989,1990] and Fish and Purr [1991] and by Butterworth and Faugier [1992]. All these works have provided comprehensive reviews of the literature which identified numerous models of supervision and roles played by the supervisor within them. Empirical evidence, however, has identified a poor definition and understanding of the role in practice, which, for Fish and Purr [1991], reflected a lack of value given to it.

The supervision of learners has been an established role in the practice setting [Merchant 1992]. However, the nature of this supervision again reflected the model of learning and practice in evidence. Fish [1989], [cited in Fish and Purr 1991], noted that within a model of 'learning through practice' the role of supervisor changed. It had been identified that learners as workers assumed a role in the practice setting which relied upon their service contribution and placed their learning needs secondary to this. Supervision of this worker was suggested to have been orientated for the benefit of the organisation, rather than their professional development [Melia 1987]. Redfern [1981] noted classical organisation theory which maintained that hierarchies should ensure effective control of employee performance and the achievement of organisational goals. She

further noted 'the hierarchical principle should produce a clear line of authority and communications structure in which each employee receives direct orders from one supervisor only'. Ryan [1989] recognised this structure within a system which fragmented work and knowledge at the clinical level and this was suggested as the basis of the apprenticeship model of learning practice. In this situation, Ryan [1989] argued, control and authority lay at the supervisory level and necessarily accountability, decision making and information would be passed away from the learner to the supervisor. Holloway and Penson [1987] concurred and noted it as a feature of the 'semi-professions', to which nursing was seen to belong [Etzioni 1969, cited in Holloway and Penson 1987]. In contrast, within professional practice which engendered individualised care, the patients and the nurse who looked after them retained responsibility for decision making. Practitioners other than this nurse, he suggested, would have a role in supporting the care giver and in allowing their practice to grow, develop and change.

Ravey [1992] suggested that in its simplest terms supervision was concerned with overseeing anothers work and ensuring that it was done correctly from an organisational as well as professional view point. Other literature [Hill 1989, Ryan 1989, Fish, and Purr 1991, Butterworth and Faugier 1992] suggested it was a means of professional education and development and therefore implicit in the teaching role [ENB 1989, Clifford 1992, Crotty 1993]. Butterworth [1992] reported little in the literature on

supervision in mainstream nursing which was 'related to the maintenance of standards, rather than the encouragement of professional growth'. His work presented three main arguments;

[i] that models of clinical supervision can be developed in nursing which protect and improve upon clinical practice and give nursing the necessary support it needs to mature into greater independence.

[ii] clinical supervision is a model which must endure throughout professional life, thus providing a supportive as well as an educative purpose.

[iii] clinical supervision is an enabling process and involves not only penalties but an opportunity for personal and professional growth.

In consideration of the process of supervision, the importance of the student-supervisor relationship has been identified [Bodley 1991, Ravey 1992, Twinn 1992] with good communication being central to this [Kermode 1985, Fish and Purr 1991]. Good interpersonal skills on the part of the supervisor [Marriott 1991] and the development of trust in the relationship have been reported as necessary for this role to be effective [Curiel and Rosenthal 1987]. Bodley [1991] suggested that support, teaching and assessment were all important roles in supervision, particularly in mental health nursing.

Support.

The centrality of practitioners in the process of teaching clinical practice has shifted the responsibility for this process away from education staff. This movement has been evidenced by the change in their role from teaching practice to supporting the student in the clinical environment [Payne et al 1991, Clifford 1992 and Crotty 1993]. The need for support for students in their

practice placements had been well established in the literature [Flagler et al 1988, Booth 1992, Wainwright 1992], whether from the staff in the practice environment [Twinn 1992], other student colleagues [Wyatt 1978, Jacka and Lewin 1987, Windsor 1987], or the school [Sloan and Slevin 1991]. The reported benefits were that students developed more self-confidence [Flagler et al 1988], their learning was improved [Wong and Wong 1987, Flagler et al 1988, Jarvis and Gibson 1985] and that it prevented feelings of depersonalisation and burnout [Booth 1992]. The absence of support, particularly from ward and teaching staff, has also been documented [Frith et al 1986]. The findings by Flagler et al [1988] and Booth [1992] showed that, rather than the individuals, a generally supportive environment was at the heart of this since staff who were supported themselves were more able to be so for students. Similarly, Jarvis and Gibson [1985], Windsor [1987], Wong and Wong [1987], Flagler et al [1988] and Twinn [1992] all drew attention to the importance of the relationship. Twinn [1992] suggested the possibility of role conflict if, as in the community setting, the person able to support the student was also their supervisor and therefore had a role in evaluating student's practice. In this situation, they may become the source of the student's stress.

The literature was less conclusive on what constituted support. Indeed, Booth [1992] identified a difficulty in defining this term. She made a distinction between professional support and the relief of distress, although she noted that this difference was

not always apparent. Her review of this concept was placed within the orbit of supervision and it was therefore suggested as a facet of this role. However, Darling [1984] and Wainwright [1992] both identified support as a facet of mentorship. In his discussion of mentorship in nursing, Wainwright [1992] reported three kinds of support necessary in professional practice; instructor support, head nurse support and peer support. However, no mention was made of the activities involved in these. In terms of the relief of distress, Hyland et al [1988] reported that students experienced stress, and therefore required support, on three counts; starting work for the first time, being in an unfamiliar environment and the realisation that their actions were important to other people. The importance of relationships with ward staff to resolve these was again identified.

Assessment of practice.

The purpose and process of the assessment of practice have been suggested as a reflection of the approach to learning adopted. As the move has been away from a formal, traditional application view of education and practice, so the assessment process has moved away from a preoccupation with performances, to that based on the students learning needs [Woolley 1977, Adderley and Brock 1977, Fish and Purr 1991]. MacCaugherty [1991] noted that even within an educational system that recognised the importance of the practice setting as a learning environment [ie Project 2000], practice and theory assessments were still kept quite separate. Consequently, competency in practice remained divorced from the

curricular goals.

There were four basic issues concerning the process of evaluation in the clinical setting that arose within the literature:

[i] Since assessment was based on direct human observation in an unpredictable environment, it was suggested to be inherently subjective [Wood 1982, Price 1986, Jarvis 1983, Woolley 1977, Wong and Wong 1987, While 1991].

[ii] The difficulties of ensuring a student worked with the same person consistently meant the assessment was inevitably based on a sample of the students total experience or was completed by inference [Long 1976, Wood 1982, Watts 1989, While 1991].

[iii] It would be ideal to separate learning and evaluation, so that the student was not judged before s/he had a chance to learn. However, this was recognised as impractical [Wood 1982, While 1991].

[iv] It was impossible to provide students with identical situations on which they were evaluated, so assessment became a reflection of the opportunities offered [Wood 1982, Twinn 1992, While 1991].

Given the difficulties identified above, the purpose of assessment was to decide whether a student was competent in practice. Jarvis [1983] questioned whether competency was the goal of professional education, or the goal of training. He argued that competency to enter a profession did not depend on having reached a certain level in knowledge and understanding, skills and professional attitude [the facets of professional practice], but rather on being able to successfully negotiate the appropriate qualifying exams demanded by the profession. He conceded that there may be other reasons for assessment, but their use or ability to test competency to practice must be called into question.

The nature of the assessment process produced debate which reflected the goals of the educational process. Fish and Purr [1991] suggested the assessment of practice should concern the principles and procedures of learning through practice. While [1991] noted, however, that clinical assessments were designed to test behavioural skills, rather than intellectual ones. She predicted that assessment within Project 2000 would add to the difficulties of assessment in practice through the inclusion in their programmes and, therefore, the use of creative and critical thinking and reflection in the clinical situation.

The learning environment.

A large literature has identified the clinical environment as the place for students to learn clinical practice. Students interviewed by Burnard [1988a] reported learning in the clinical setting as more real than that which occurred in the classroom.

Alexander [1983] compared a college based programme with one which was ward based. Her evidence showed that a ward based programme with more active involvement of tutors and students, produced positive links between what was taught and what was practised. Bendall [1975] highlighted discrepancies between the ideals espoused by the school and the realities of the practice setting and Gott [1984] was critical of the expectations placed on students by the school of nursing; indeed, she provided evidence to show how nurse teachers failed to prepare students for their job in the wards. Ryan [1989] also identified the

importance of the clinical environment in student learning; 'in a practice-led profession, the real curriculum is experience'.

The organisation of care.

In the clinical setting, the environment in which nursing care was given has been shown to have a significant influence on students learning experiences. In particular, the organisation of care has been shown to influence students in a number of respects. It has been suggested, for example, that the environment was an expression of the kind of nursing care practised within a clinical setting and, therefore, that to which the student was exposed [Drummond 1990]. Moreover, there was reason to believe that the environment had an influence upon who was available for students and, therefore, the opportunities for supervision and mentorship which occured [Fretwell 1982, Reid 1985, Proctor 1991, Jowett et al 1991]. Reid [1985a] noted the importance not only of the numbers of staff necessary for good learning, but also the skills of those present and Proctor [1991] related the latter point to the determination of the system of care giving. Within Project 2000 poor staffing and the consequent staff mix, resulted in not only loss of supervision, but also loss of educational opportunities since students were drawn into service to fill the gaps [Jowett et al 1991].

The difficulty of drawing distinctions between environments which claimed to subscribe to one system, or another, was identified by the Audit Commission [1991]:

> 'Terms such as patient allocation, team nursing, primary nursing by which nurses categorise the different approaches to organising care can cause confusion because they are not used consistently. In practice the boundaries between them are blurred. Organisation of care can also vary between shifts. For instance although task allocation has virtually disappeared as a planned method of organising care, the proportion of work still actually undertaken on this basis increases considerably outside the 'early' shift. Thus some wards operating primary nursing still have very task orientated delivery of care at nights and during periods when wards are short staffed or heavily reliant on temporary staff or students'.

Early work by Fretwell [1982] and Orton [1981] identified features of task allocation and team nursing which were not conducive to student learning. Fretwell, for example, described the system of task orientated, repetitive work allocation found in her data, and considered a feature of team nursing [Merchant 1992] as 'the antithesis to a learning environment'. Infante [1985] similarly reported that 'routine tasks provoke little exploration and curiosity on the part of the student'. Spouse [1990] identified four further studies which concured with this impression [Hamilton-Smith 1972, Wright 1974, Bendall 1975 and Jones 1975 cited in Spouse 1990].

It has been suggested that the key to securing good student learning in practice, was through exposure to an individualised approach to nursing care [Pembrey 1980, Davis 1990], which underlies the nursing process [Audit Commission 1991]. Butterworth [1992] noted the change within this, away from 'task-centered work'. More recently, primary nursing has become an area under consideration and investigation. The Audit Commission [1991] were charged with an examination of the

management of ward nursing in acute general hospitals and, within this, the organisation of the delivery of care. Despite stating 'there is no conclusive research evidence on the effectiveness of primary nursing in improving clinical outcomes in ways that can be quantified' the Audit Commission did concede a growing professional opinion in its favour.

There have been a number of works [see for example, Pearson 1988, Beardshaw and Robinson 1990, Drummond 1990, Burns 1991 and Manthey 1992] on primary nursing as an environment which promoted professional nursing care, and hence embodied the characteristics of practice envisaged for the new diplomates. Manthey [1992] wrote on primary nursing from the perspective of those who practised it 'the primary nurse [working in this context] is the most logical one to prepare the students for the real complexities of professional nursing practice'. Her reasoning lay in the ease with which this person could assume the dual roles of clinician and teacher and in the basic assumption that this produced a superior teaching process. Although this work concentrated on presenting a logical argument for the promotion of primary nursing, empirical evidence to support this assumption had been provided by Williams [1981] Harper [1990] and Drummond [1990].

Harper [1990], in a short report, gave details of a study he conducted with post-enrolled conversion students on their learning in clinical placements. His sample was small and there

was no discussion of method. However, he suggested that the type of nursing system used in clinical settings was important to students experience; his students prefered primary nursing over team nursing. Williams [1981] compared students learning experiences in both team and primary nursing settings. Although the study was conducted in the United States, and may therefore be limited in its generalisability, she identified the importance of primary nursing in providing students with the opportunity to follow patient care through from admission to discharge. Drummond [1990] developed this further and presented an argument, based on his own research findings, that team nursing contradicted the aims and ethic of Project 2000, through giving rise to a 'bureaucratic cognitive style' of nursing practice. In contrast, primary nursing through its 'professional cognitive style', allowed students to participate in the whole decision making process required during individualised patient care.

In contrast, Proctor [1989] addressed the question of how the training programme influenced the organisation and implementation of patient care. Her empirical work concluded that the present system of placement areas reliant upon a transient workforce of learners for their staffing needs, imposed a structure which was based on the skills of the staff available, rather than the needs of the patients. The ward sisters in her study found themselves in a situation of having to choose between continuity in the allocation of nurses to patients, and the supervision of untrained staff. She suggested that this inhibited the

development of professional nursing practice. One means for learners to lessen the insecurity of working alone and for ward sisters to be able to rely on their contribution, was through the adherance to ward routines and procedures.

This theme of rigid routines and task allocation being of benefit to students within a system of team nursing had been identified prior to this work [Fretwell 1982, Holloway and Penson 1987]. Indeed, Braby [1990] reported the provision of such duties as a 'status passage into nursing' for students . The conclusions drawn, however, were that the system of delivering nursing care required change as much as the organisation of educational programmes; indeed, one could not happen without the other. A discussion paper by Ryan [1989] on the effectiveness of modular schemes of basic nurse education and training for the University of Edinburgh, has cast doubt on the success of the former in the absence of a reorientation of practice. He presented an account of two contrasting models of management structure to highlight a view that Project 2000 had been constructed 'back to front'. Organisational constraints were the factor which inhibited the development of professional practice, rather than the educational preparation of practitioners. Effecting a change in practice through a change in the preparation for practice, gave responsibility to the weakest member of the organisation; the learner. His conclusion was that the outcome of this would necessarily be to the detriment of the learner [by preparing them for a role that did not exist], rather than to the benefit

of professional practice.

> 'Learning systems and practice systems should be matched. If one doesn't like the practice system it is the practice system one should change, not expect it to be changed by new model learners.... Environmental influences are very constraining , and it is contrary to common experience that one can change an environment by sending in an anomaly; Environments get changed by substantial shifts in the major systems which determine them, not by plucky misfits'.

For Ryan [1989] change should be in two phases; Project 1999, achieving new practice, followed by Project 2000, preparing for practice.

The sense in which this sentiment and other issues raised by this Review of the Literature, has been earthed in the present empirical research, follows the next section in the document, which is an account of the methodology by which it has been conducted.

Introduction

The Research Team developed a methodology, approved by the Steering Group, by which the study could be undertaken to satisfactorily address the three Aims, which themselves covered the seven areas of interest to the ENB. From an overview of the methodology provided below, it can be seen that, following preparatory work, a two stage study was designed.

Preliminary investigations

* Focused interviews with key figures in nurse education [n=5]
* Scrutiny of P2K course submission documents [N=42]
* Self-completion questionnaire to Principals [N=42]

Stage 1

* Semi-structured interviews in three centres with:-

ADULT BRANCH	MENTAL HEALTH BRANCH
Students [n=30]	Students [n=23]
Practitioners [n=17]	Practitioners [n=20]
Tutors [n=17]	Tutors [N=8]

Stage 2

* Six case studies:-

ADULT BRANCH	MENTAL HEALTH BRANCH
3 case studies [one in each of three centres]	3 case studies [one in each of three centres]

Each case study comprised of three separate practice settings, in each of which the following data collection methods were adopted:

Observation
De-briefing interviews
Extended interviews
Documentary evidence

As many of the central research questions and interests were complex and contentious, a clear impression confirmed by the preceding review of the substantive literature, an interactive approach was favoured. A qualitative field research strategy [see Fielding and Fielding 1986, Lofland and Lofland 1984] was agreed, including case study [see Yin 1984], which provided the Research Team with an opportunity to try to understand the thoughts, feelings and experiences of those directly connected with student learning and to focus on direct, face-to-face, knowledge of their circumstance in natural social settings. In so doing, the interests of the first and second Aims of this study were accommodated. Appropriate data collection methods were decided to include tape recorded interviews, non-participant observation and documentary evidence.

As the second Aim suggested, this study focused on two Project 2000 Branch Programmes; Adult and Mental Health. These Branches were chosen, not only because they represented the two largest student intakes of the four that were possible, but also because relevant substantive expertise was available for both, from the two collaborating Universities. The methodology, therefore, not only took cognizance of the two different Branches, but also the different contexts in which student learning took place; viz, in both hospital and community settings.

A manageable timetable of research activity was charted [see Appendix 2] to accommodate the two-stage research design.

Preliminary investigation

[i] A series of wide ranging preparatory interviews were undertaken with five experts in nurse education, as a means to explore the context within which the study was to take place and to become familiar with the width of substantive issues involved. These key informants were identified by a process of consensus within the Research Team.

[ii] Having sought and received written permission from the appropriate Institutions, all forty-two Project 2000 course submission documents which had been received by the English National Board for validation purposes, were scrutinised. The Research Team focused the examination of these documents upon the way in which roles had been identified to facilitate student learning in practice settings and on the titles assigned to these roles.

[iii] A follow-up survey [see Marsh 1982] was then undertaken, in which the Principals of all 42 Institutions were contacted in writing. Each respondent was invited to confirm the titles used in their local centres, which identified the roles occupied by the practitioners and tutors, who were formally instrumental in helping Project 2000 students to learn in practical placement areas of the Adult and Mental Health Branch Programmes. In addition, the Principals were invited to identify the functions performed by the occupants of each role title. The purpose of

this enquiry was to gain an indication of the properties of all the roles identified and to better understand the dimensional ranges of commonly used terms [see Appendix 1].

Stage 1

In April 1991, when preliminary work on this study began, thirteen centres in England had commenced Project 2000 courses, and thus comprised the sampling frame. Six of these were the focus of a Government-funded study undertaken by the National Foundation for Educational Research [NFER] which aimed at a broader evaluation of the implementation of Project 2000. These centres were automatically excluded from the options available in order to avoid the problem of over-researching. However, the present study was to benefit from the perspective provided by the Principal Researcher on the NFER study, who was recruited to the membership of the Steering Group.

The remaining seven centres were approached to establish their willingness to participate in the present research. One centre declined because of ongoing local research, while another centre, also the focus of a local evaluation, declined to participate in the main study, but offered to make themselves available for pilot work. This centre was involved in the pilot of Stage 1 research instruments. The remaining five all expressed a willingness to be fully involved. The three Colleges furthest into the Branch programme at the time when data was to be collected [and thus had the most experience to account] were

finally selected as the main study centres. One of the two that remained, was selected for Stage 2 pilot work. Although all three main study centres were in the South of England, they were respectively located in rural, urban and inner city areas.

In order to identify and explore the issues most pertinent to student learning in practice settings, it was essential to capture the views and experiences of the key actors: and by this was meant the students, the tutorial staff and the clinical practitioners. This triangulation of respondents allowed the perspectives of the main participants in student learning to be compared and to highlight any ambiguity and potential conflict within roles. Focused, semi-structured interviews were considered an appropriate vehicle to explore an understanding and interpretation of the key terms which appeared to recur in both branches.

Development of Stage I instruments

The Project Team identified a list of themes and issues, which had emerged from the preliminary investigation, and broad topic areas were translated into specific questions, which were then refined. Two separate interview schedules were produced [see Appendix 3], one for tutors and clinical practitioners, and one for students. The instrument designed for qualified nursing staff included items related to the present and, on the basis of any reported shortcoming, predicted educational preparation of different role holders, whose appropriateness was explored; in

so doing, the third Aim of the study was addressed. In common with that designed for students, and to specifically explore the pre-specified interests of the ENB, the qualified staff schedule included items which attempted to locate and explore models of good practice, from which lessons could be learnt. Both schedules were developed for use with both mental health and adult branch participants, to allow comparability between branches. Each was piloted in two non-participating centres, one in the North of England the other in the East and minor alterations were made as a consequence.

Access to study centres

Having ascertained the willingness of individual centres to participate in the study, the Research Team sought and obtained written approval from the local Research Ethics Committees of each Health Authority, in which student practice placements at the pilot and main study centres were provided. In each of the three centres for the main study, an introductory visit was arranged for members of the Research Team to share information about the project and make the logistical arrangements for data collection. A wide range of people were invited to attend including the College Principals, Course Leaders, Branch Leaders [from both mental health and adult], practitioner representatives from both institutional and community placement areas and student representatives. These meetings proved worthwhile in the dissemination of information about the proposed research and in making contact with potential respondents, as those present were

usually the conduit by which appropriate tutors and service staff could be approached for interview. Separate meetings were arranged with student groups, in both Branches, to explain the aims and methods of the research and to request volunteers for interview. A written abstract of the research aims and study design was widely disseminated within the study centres.

Stage I Sample

Purposive samples were drawn of tutors, practitioners and students, in relation to both the adult and mental health Branches, in each of the three main study centres. Care was taken to reflect the characteristics of age, gender and ethnicity of the group as a whole and, in the case of students, a width of opinion regarding their experience of the course.

Interviews were conducted in each centre over a three week period and started with the Centre which was furthest into their course. Verbal consent was obtained from all participants and tapes and data sheets were coded to protect anonymity. The researchers gave an undertaking to ensure that individual respondents would have their identities rendered anonymous in written reports. Information about a respondents age and ethnicity was illicited by the use of prompt cards. The interview schedules were used as a guide, to ensure that all topics were covered, but scope was also provided to explore unpredictable areas of interest in more detail. Each interview lasted between thirty and ninety minutes and all were tape-recorded.

Stage I data analysis

Data analysis proceeded concurrently with data collection, on the basis of hard copy manuscripts produced from a verbatim transcription of the interview tapes [see Appendix 4, for an example]. It became apparent, however, that the themes which emerged for each group of respondents [students, practitioners, tutors] quickly approached saturation and the necessity for the further transcription of all interviews, for the sequential analysis to continue, was questioned. The Research Team considered that no advantage was conferred on the analytic process by working on data in a conventional hard copy format. Moreover, it considered that the methodological rigour of the analysis would not be compromised if it proceeded on the basis of actual audio-taped data, replayed to the researchers [the equivalent of a re-read of the manuscript]. Indeed, on balance, a comprehension of the richness of data was regarded more likely in the latter, than the former. Advice on this matter was sought from academic researchers, within and beyond the Steering Group, and, as a result, a decision was taken to limit the transcriptions to approximately one-third of the tapes, chosen purposively. These hard copy transcriptions were then used as an adjunct, when actual tape recordings were listened to and analysed by the researchers. The tape recorded interviews, for which a full verbatim transcript was not produced, had telling fragments summarised by hand and identified [by means of the counter numbers on the transcribing machine] for later verbatim transcription, if necessary, for inclusion in this report. This

methodological adjustment was found to work very well in practice.

In order to organise these fragments of data in a coherent fashion, an A3 size matrix was constructed with the categories from the content analysis down one axis and individual respondents across the other. Three of these matrices were made for each Branch; one each for student, practitioners and tutors data. This structure of empty cells thus handled the products derived from a Content Analysis [Holsti 1969] of the interview data. This involved the extraction of telling fragments of datum from each interview which could be located in a relevant cell. Issues which emerged and did not fit into an established category, were added to the axis to approximate categories which were mutually exclusive and exhaustive. Such a method allowed a comparison to be made between respondent groups, between Branches, settings and Centres.

Stage 2

In order to explore and develop a deeper understanding of the issues emerging from Stage I interview data, six separate case studies were undertaken as the basis of the second stage of data collection. The case study approach required the analysis of contemporary phenomena within their 'real life' context (Yin 1984) and provided a detailed and multi-perspective account of experiences and processes within the case study setting. This was a highly appropriate method for the present study to adopt, as

it focused on the 'lived' experiences of those undergoing change and so specifically addressed the interests of the ENB.

In total, six case studies were planned; three to focus upon the experience of students in the mental health branch and three in the adult branch. One case study was undertaken in each centre for each branch to cover a range of community and institutional settings. A setting usually comprised either a hospital ward where students were placed, or a non-hospital facility, usually a Health centre [see Appendix 5]. Exceptions were observed in Mental Health, where an organisational arrangement of client allocation, transcended the conventional notion of a 'placement area'.

Settings were selected within the three Centres, according to the following criteria;

* that students would be available in particular settings during the time window for data collection.
* that students, clinical and tutorial staff were willing to participate in the work.

It was initially expected that the selection of the case study settings would be able to satisfy a third criterion; viz, as a result of a consensus amongst Stage 1 respondents, a particular setting was viewed as a positive learning environment for Project 2000 students [a so-called 'good model']. However, in the event, the Research Team found that such consensus between respondents, did not exist. Moreover, respondents often hesitated, and/or offered caveats, before they committed themselves to

identify any setting as a good model of practice for student teaching, support, supervision and role modelling. This feature occurred at all three Centres and, as will be apparent later in this document, meant that one of the pre-specified interests of the ENB would prove very difficult to satisfy.

The main methods of data collection employed within each case study included non-participant observation [Appendix 6], tape-recorded periods of actual interaction and semi-structured interviews [Appendix 7]. The main focus for data collection was the student's learning experiences during pre-specified work periods. In order to gain an insight into the processes involved in their clinical learning, students were observed during two working days [often traditional shifts] on two separate occassions. Each period of observation was followed by a separate debriefing interview [Appendix 8], both with the student and the main person identified to help them learn within the practice setting. Insight into aspects of organisation, such as role differentiation, teaching strategies and the student's consequent experience, was developed by means of in-depth interviews with other key personnel involved in facilitating the student's learning. Data derived from these data collection methods again addressed all the ENB interests and all the Aims. A profile was developed for each setting, from data derived from a structured questionnaire [Appendix 9] and separate documentary sources.

Observation

During periods of observation, the researchers made field notes, maintaining a record of the student's activities during each work period and, in particular, a record of incidents thought to be relevant to the student's learning. Since observation focused on the student, the researcher [in effect] 'shadowed' the student throughout the period of observation, even when the designated supervisor was no longer present. Interactions with other staff members thought to be significant in relation to the student's learning were also recorded in field notes. Such a researcher role accorded with the conventional notion of 'observer as participant' [see Polgar and Thomas 1988].

Selected periods of interaction during which the practice supervisor and student were obviously engaged in a potential teaching/learning situation, were captured in detail on audio tape. Such opportunities were easily identifiable, and often predictable. Examples included periods during which a supervisor and student were planning care, or identifying priorities; when the practice supervisor was demonstrating an aspect of patient care; attendance at meetings [including those with other disciplines] and when [say] a supervisor and student were involved in drug administration.

Following each period of observation, tapes were played back and each recorded episode was located in the field notes. Fragments of the data were then selectively transcribed, identifying

examples of strategies employed by participants which appeared to assist or hinder the student's learning. This process was repeated for each tape-recorded episode, within the setting, for both periods of observation.

Debriefing interviews

The debriefing interviews were held, when possible, immediately following each period of observation. Interviews were semi-structured and tape-recorded. Three main areas were addressed within each debrief: events during the period of observation which the respondent felt had helped the student to learn, events which had hindered the student's learning, and whether or not the respondent felt that the period of observation had been typical of their general experiences within that role and setting. In addition, the researcher explored any particular incidents which were noted during the period of observation as critical incidents [Flanagan 1954], if these were not highlighted by the respondents themselves during the interview.

Extended interviews

Extended interviews were also conducted with the main participants in the student's learning within each setting. This always involved the student and the practice supervisor and, in addition, may have involved the ward manager/senior nurse, link teacher and other members of the ward team closely involved with the student. Here too, interviews were semi-structured and tape-recorded. The interview schedule was developed around

issues emerging from the Stage I data which required further exploration, including the interpretation of supernumerary status, levels of assessment, mechanisms for linking theory to practice and the preparation of staff to perform particular roles.

Ethical issues

Verbal consent was obtained from student and practitioner respondents prior to the commencement of fieldwork in each setting and immediately prior to each period of observation and interview. At the beginning of each 'shift' of observation in a ward setting, the researcher introduced her/himself to patients likely to be involved in observation/tape-recording and gave a brief outline of the study. Verbal consent to participation in the study was sought from all patients in both institutional and community settings. All tapes and field notes were coded to protect anonymity.

Piloting Stage II instruments

Stage II data collection instruments were piloted in two separate centres not involved in the main study. Observation protocols and debriefing interviews were piloted in relation to both the adult and mental health branches in two ward and two community settings, involving one day of observation in each placement.

Following pilot work, two important issues were identified for further discussion:

* the need to observe students and make fieldnotes during periods when they were working alone, in order to be aware of incidents which the student might choose to discuss with their mentor when the opportunity arose;

* the need to establish potential teaching and learning situations with mentor and student at the beginning of each period of observation and to make these the focus for tape -recording.

These two points were incorporated into the main study protocol.

Methodological critique

Case study methodology [Yin 1981] provided an appropriate way of dealing with the undeniable complexities of this research project. It was selected following extensive debate by the project Steering Group and the Research Team are confident they it provided a sufficiently robust methodological framework. Like all other methodologies adopted by social scientists, it imposed limitations and the Research Team recognised these and worked within them.

It is important that the reader accepts that the interpretation of data gathered for this study and, therefore, the following findings, have been produced following rigorous analysis, verbatim transcription and by the comparison of data drawn from different sources. It is inevitable, however, that some researcher bias will be present and that representativeness was neither sought, nor claimed, for this work. The reader must compare the theoretical insights derived from this study to their own experiences and previous research, and look for common ground.

FINDINGS

Introduction

The findings presented here have been derived from the analyses of Stage 1 and Stage 2 data, which were collected by methods previously described. The information reaped from the three preliminary investigations, also referred to previously, was instrumental in the development of these methods. The findings from the background survey of forty-two Principals of educational institutions, who had submitted Project 2000 course documents to the English National Board for approval [which were examined by the Research Team], have been lodged as Appendix 1.

In the following section of this document, findings from Stage 1 of the study will be presented first. These will relate to the semi-structured interviews with the three respondent groups [students; practitioners; tutors], in the two Branches, across the three Centres. Next, findings from Stage 2 of the study will be presented. These will relate to periods of direct observation, documentary evidence and interviews, within a case study design, in three Centres and for both Branches. Each sub-set of findings will be signposted with a bold heading to identify the respective Stage, the Branch, and the Respondents or Case Study area. In addition, each sub-set of Stage 1 findings will be prefaced with a tabulated summary of respondent characteristics, the greater detail of which has been listed in Appendices 10-14. Each will be suffixed with a summary.

Thus, the sequence in which each sub-set of findings has been ordered into a coherent presentation, will be as follows:

Stage 1 [Interviews]

Adult Branch:
- Students
- Practitioners
- Tutors

Mental Health Branch:
- Students
- Practitioners
- Tutors

Stage 2 [Case Studies]

Adult Branch:
- Centre A
- Centre B
- Centre C

Mental Health:
- Centre A
- Centre B
- Centre C

It can be seen that for Stage 2 findings, Case Study centres have been identified with an anonymised code letter 'A', 'B' or 'C'. These codes relate to the same location for both Branches.

The convention adopted throughout this report has been to include fragments of raw datum, either to make or develop points of argument. Such fragments have been drawn from the whole data set available and not solely from that which was transcribed onto hard copy. Without exception, these fragments have been reported in an unedited verbatim format, even when the language used was explicit, or the issue to hand was sensitive. On occasion, however, reference to the sex of an individual may have been changed in this document, to avoid possible identification.

Stage: 1
Branch: Adult
Respondents: Students [n=30]

Summary of respondent characteristics:

Sex		Age					Ethnicity	
M	F	18-23	24-29	30-34	35-39	40-44	White	Other
9	21	20	4	2	3	1	28	2

Qualifications [highest gained]

'O' Level	'A' Level	Degree
15	12	3

Accounts of experiences reported here were all drawn from Adult Branch students of a Project 2000 course, who, at the time of the interviews, were into their second Branch placement. Thirty students were interviewed, ten from each of three centres A, B and C (for more detailed characteristics of sample, see Appendix 10). In all centres, respondents comprised part of the first cohort of P2K students. Only six of the thirty students had specifically applied for the Project 2000 course. All others had originally applied to follow a conventional Registered General Nurse [RGN] course and had either found out at the recruitment interview, or had been informed by a prior letter, that they had actually been considered for a Project 2000 course. They reported a universal lack of knowledge about the difference between the two. Many students had been required to state their Branch preference at the outset of the course and were not encouraged to reconsider this.

The context of practice

Due to the variations in the CFP courses in each centre, the students had received different amounts and types of clinical experience. However, in broad terms, most had had study periods in College, followed by community placements and then hospital placements which included the four different Branches of nursing practice (adult, mental health, child and learning disabilities) and their associated community environments.

Students valued clinical practice because it provided opportunities for them to see the relevance of things they had been taught in College. This was expressed as the reason many students were pleased to be in the Branch, because they felt they then gained 'real' clinical experience. It was also seen as the only place to 'really' learn clinical skills.

> "We were taught injections in school, we practised on bits of rubber but it's completely different from the real experience. You really learn the actual skill from being in the ward".

However, all students were concerned about the limited amount of time they spent in clinical areas. Universally, they reported that short placements periods did not allow them time to "settle into" an area and build up relationships with clinical staff, the importance of which was acknowledged:

> "I realise I need to get on with the staff, integrate, so I don't just go up and make demands, particularly in the first few weeks".

Students noticed a difference between what was taught in school and what was observed in practice and particularly valued the knowledge and skills of practitioners. Students believed they

were given an idealistic view of nursing in College and many reported the importance of ward staff for helping them to link theory and practice.

> "We have so much theory, but we need them [ward staff] to put it into place. They have the experience and the know-how".

However, more frequently, the Link Tutor was reported as more important in this respect;

> "You need someone in the ward who knows what you are talking about to help you use what you are learning in the school in the ward. The link tutor is important here".

This was put into perspective, however, by another student from the same centre, who reported that a tutor had taught about a model of nursing and expected the student then to use it in practice. The ward staff were not familiar with it.

Students were asked about what they did in the placements and about what it meant to have supernumerary status. They reported a mismatch of expectations between staff in the wards, tutors and themselves about their role in the practice environment. The focus for this mismatch appeared to be in the understanding and expression of supernumerary status.

The most common misinterpretation perceived by students was that staff in the placement areas believed it meant that students did not participate in giving care, but simply observed. In all centres, students reported that many staff did not know what the students could, or should be doing. Some students were concerned because they too were unsure what was expected of them.

> "When you first started in the course you didn't feel like a student in the school but you also didn't feel like a nurse in the wards; you don't know where you are".

In placement areas, such uncertainty restricted students participation at times and denied them the very learning experiences they were seeking. For others, it gave them the freedom to participate in the way they wished in order to maximise their learning opportunities. Many students described this freedom as the best thing about supernumerary status.

However, this was not without problems. In one centre, the College became aware of the extent of the students participation in care giving and believed this to be too much at that particular stage in their preparation. Consequently, a list of activities was published, which identified what students were and were not allowed to do. Students regarded this as a restriction to their learning experiences.

Students themselves defined supernumerary status, without exception, in manpower terms; "it means you are not counted in the numbers", although many clarified this further by noting "but it doesn't work in practice". They were able to articulate both what supernumerary status was not;

> "It doesn't mean you haven't got any responsibilities and it doesn't mean you stand around and watch".

and what they would like it to be;

> "I would like it to be that I am allowed to take part in what's going on, but allowed the time to learn things without being relied on".

However, this ideal was not always realised in practice.

Students described what they did in placement areas in terms of a trajectory, which started with observing other people at work, and which moved on at a varied pace [for a substantial number of students] to being allocated their own patients. This was usually in conjunction with another more experienced member of staff. The students realised that they had changed during the course of their programme and with this their learning needs had changed also.

There was a feeling of relief at having moved on to the Adult Branch. Most described their clinical time in the CFP as having been spent as an observer. When students had participated, this was explained in terms of tasks and these mostly "basic care";

> "Initially I mostly observed, took the odd BP. Later [in the CFP] I got more involved and aquired new skills - BP's, aseptic technique, bedmaking, basic care".

Many students disliked this observation role and were keen to get involved in giving care. The main reason reported for their discomfort was the practitioners' perception of them in this capacity. They felt 'in the way' and a 'burden' to staff when observing and as if they were not participating as the staff expected. More importantly, many expressed doubt about this as a learning activity, particularly at that stage in the course.

> "Observing doesn't work; you learn the mechanics, but you need to reinforce what you've seen".

> "Observing is exactly the way you don't learn, at this stage [in the Branch] it's too late to be observing".

However, on reflection, a number of students valued this time in their experience, but were glad to have moved on from it as a singular role. Most expressed relief at finally being in the Branch and in "proper placements" where they could "start to learn what they came to do"; "in the Branch you are actually learning your trade".

The pace and extent of this progress was determined by a number of factors, some of which were within the students control. Students reported that practitioners expected them to take responsibility for their learning, through placing the onus on them either overtly, or otherwise, to approach staff for learning experiences.

More specifically, practitioners expected students to turn work into learning, by asking questions as they went along. Students ablilty to do this depended on how confident they felt, how directed they were and, crucially, by the reception they received from those they approached; "you need to have a good relationship with staff before you are able to approach them".

A possibility existed for students in the Adult Branch to 'become part of the workforce' and so put at risk their supernumerary status. Thus, on the one hand, students wanted to feel part of the ward team and thought the best means of so doing appeared to

be through getting on with the work; "to pull your weight". Some students were willing to compromise their supernumerary status to this end. On the other hand, however, such a trade-off introduced the risk that students would be relied upon to give care and, therefore, miss the opportunities that arose for their own learning. One student was clear about the personal implications of this;

> "If it's very busy you are relied upon to do things and so it stops being learning and becomes work".

All students had experienced times when they were either explicitly being relied on for their service contribution, or found themselves faced with a moral dilemma, in which they were called on to provide for patients at the expense of a learning activity; "you can't just say I'm supernumerary and walk away".

One factor that affected the students role in clinical areas, over which they had no control, was their uniform. Their appearance prevented them from being able to conceal the fact they were a Project 2000 student and this made them feel different. Students also felt that the lack of uniform prevented them from being accepted into the ward team. In one Centre, students did not wear a uniform in the CFP and linked this to their feeling of exclusion and neglect by practitioners. The intensity of this discomfort is made plain by one student;

> "If you wore the same uniform, people wouldn't treat you so differently. It underlines the differences. It isolates you and people judge you by the colour of your dress, rather than the person underneath. It's like being a black person".

such, tutors then became important and were often described as a "safety net" in this respect. For all students, the tutors were different to the ward staff, in one important respect as an influence on their learning; viz, that they were not linked in any way to the demands of service and so had [in a comparative sense] the necessary time to give the students.

Some students had been allocated to a team of people, rather then one individual in a placement area. Such collective responsibility was reported not to work. Students in all centres noted the need to have a focus for their learning.

> "You need to have one person to home in on, otherwise you'd just be totally lost. In my maternity placement, I didn't have a mentor and I just drifted really".

A recurrent theme which emerged from these student data, was the importance of the relationship the students felt they had with those with whom they were working and learning. The need to develop a good relationship with mentors was paramount to ensure the student was assisted in meeting their learning goals.

> "They [mentors] teach you, assess you and praise you, but if they criticise you, because you have a good relationship with them, it's OK".

Students talked of their different needs expected from this relationship over time and related this to their growing confidence and skills. Although this needed to be a close relationship at the beginning, later on it was reported that to have license to approach and communicate freely with this person was more important.

"My relationship with my mentors has changed over time. This is probably a reflection of my skills and how I have developed. I need a less close relationship now since I am more independent".

Just as the students talked of the need for a mentor early on in their course, the start of each new placement was repeatedly described as a time when students needed support and supervision from someone; preferably their mentor.

"You need mostly only to spend time with your mentor at the start of each shift to help organise priorities of care and then you can get on with it".

Students talked of the mentors who needed to "get to know what you can do" and "starting to let go". An important feature of this process was reported as trust and it was from this that many students derived their confidence to participate to their fullest extent. One student, talking about a charge nurse with whom she had particularly enjoyed working reported;

"He gave me the freedom to do new things for myself and encouraged me to do things. He trusted me".

However, since the mentor was not the only person with whom students work, the need to get on with all other ward staff was recognised. As was intimated earlier, a sense of being part of the ward team was actively sought, and, on occasion, students would compromise their learning needs to this end. They felt obliged 'to give something back', if they were to expect staff to teach them. Some talked of the importance of their mentor as a social sponsor in the clinical areas;

"Having a mentor makes you feel more secure as part of the ward team, so you are happier to approach others".

Relationships in practice

All students in the three centres reported having been assigned to a practitioner in Branch placements. This person was to be responsible for their learning for the duration of the placement. In two centres they called this person their mentor and, in the third, practice supervisor. There was not a difference of substance between the two roles.

Mentors [in the generic sense of the term] were always available to students in the Branch placements, but not universally so in the Common Foundation Programme [CFP]. Many students had expected such identification in the CFP and felt they needed so more than in the Branch. One student, who had asked for a mentor in a ward placement, was told she did not need one;

> "I didn't have a mentor and asked for support from staff, to work with someone. The staff said 'you don't really need to. You'll be OK'. I found it very difficult to ask and they made me feel very small".

Students were clear that their mentor should be a first level nurse from the ward, but the working reality was different. Students were rarely assigned to sisters in a formal way; most frequently to staff nurses and, on occasion, to an enrolled nurse. In the absence of their mentors, students were assigned to work on a daily basis with staff with whom they were unfamiliar; viz, bank and agency nurses, auxilliaries and health care assistants, and other conventional students.

Some students were happy to work with members of the ward team,

other than their designated mentor, even to prefer this at times.

> "Staff nurses often don't have time for students as they are so busy. Other staff can teach you. It depends on how long they have been there. Some auxillaries and students are invaluable. Sometimes it's good to work with older students....they are more on a level and are more realistic".

Frequently, students talked of the difficulty of actually spending time with their assigned practitioner and having to actively work for this. They recognised that it took time and commitment from the person concerned for the system to work and this was not always possible. Factors which prevented this included organisational difficulties, such as not working the same shifts and when mentors were on annual leave, or had to work at night.

More insidious constraints included students who were assigned to experienced members of staff, who were identified because they were the best in terms of teaching and learning potential, but also had competing demands on their time, such as taking charge of the ward. However, there was also a personal element to the perceived effectiveness of the relationship;

> "Mentors don't work when they don't understand, or enjoy, their role".

Never-the-less, there was an overriding necessity for someone in the placement area who took responsibility for the student and their learning needs. In the ideal situation, this was a mentor with whom the student had a good relationship. If this was not possible, students often found an informal mentor from the other ward staff. In the absence of anyone in the clinical area to be

Assessment of practice

All students described a similar process which they preferred to go through when they learnt a clinical skill. They liked to observe the skill being performed, then try it for themselves under supervision and then to practise in their own time until they felt confident. Such a process was enhanced if the person who demonstrated the activity was able to explain what they were doing, as they did it, and followed it through to completion; that is, the same person taught, supervised and then assessed the student. The students reported that they worked to ensure that this process happened. Here too, the practical reality revolved around the difficulty students had in spending quality time with one person.

All students believed, and some reported evidence, that mentors conferred with other staff members about their abilities prior to formal assessment, since many had not worked consistently with them. Whilst some saw this as a positive thing, there were those who were concerned about conversations to which they were not privy, and to being assessed by inference.

> "She [mentor] probably discusses it with other staff. I'm not sure what goes on behind the scenes".

Many students commented on the subjectivity of the whole assessment process. They felt that practitioners did not understand the assessment documents and were not skilled to use them, nor to determine the educational levels necessary. They recognised the influence that factors other than their performance ability could have had on the process, particularly

the nature of the relationships with both the mentor and the ward team.

> "If you upset them [the ward staff], then your assessment may not be good".
>
> "It is difficult for the mentor to be objective, especially if they like you".
>
> "If you don't get on with your mentor, it's very difficult because they assess you. It's difficult to say anything critical about the ward team, because they assess you on being a team member. You have to tread very carefully, because you have already got peoples backs up by the course [Project 2000] you are doing".

Student learning was largely determined by their assessment schedule. Those who were able to talk on such, appeared to not value, or not understand, or not use, the objectives in clinical areas and described them as "irrelevant", or "not specific enough to their placements". For some students, the value of using objectives seemed to be for the direction it gave to the placement period and their learning within it, but these had to be relevant to their needs and the opportunities in that environment. If they used objectives that were different from the assessment document, students set their own, either alone or with someone [usually the mentor] in the ward.

Above all, they wished for more practice and practice-related teaching, as the mechanism by which they could increase the potential for learning in placement areas. This was related to the expressed need for more time to be spent with practitioners, whom the students believed needed to be better informed.

Summary

Students undertaking the adult branch were very clear about the importance of having an assigned practitioner within each placement area, who was charged with the responsibility to help them to meet their learning needs. Such an arrangement was highly valued both in CFP and in Branch placements. Moreover, the nature of the relationship between student and practitioner was felt to be a key factor in determining the value of a practice placement.

'Good' mentors were those who were available to students and had a clear understanding of their own role and the student's role within the practice learning environment. Ideally, they would also have had a sound knowledge and understanding of the theoretical aspects of the course. The tutor's role within practice settings was less significant, but important as a back-up and to help students to integrate theory and practice.

In relation to specific strategies for teaching and learning, students particularly welcomed teaching which was patient-centred and orientated around individual learning needs. Clinical placements were highly valued and students in the sample were universally concerned about the limited amount of time spent in practice areas. They requested longer placement periods which would enable them to build relationships within the practice environment.

With regard to the assessment of practice, this was often felt

to lack relevance, validity and objectivity, with the inadequate preparation for practitioners cited as a major factor. Students perceived that practitioners were not well-informed about their course, or sufficiently prepared for their placements and suggested that this militated against the successful integration of theory and practice.

Stage: 1
Branch: Adult
Respondents: Practitioners [n=17]

Summary of respondent characteristics:

Sex		Age						Ethnicity	
M	F	24-29	30-34	35-39	40-44	55-59	Missing	White	Other
1	16	4	4	4	3	1	2	17	0

While a purposive sample of practitioners was drawn from the three study centres, the demographic profile reflected a wide range of characteristics, including both professional and clinical qualifications [see Appendix 11]. The clinical grading of the seventeen participants who were interviewed in this stage of the study ranged from an 'E' grade staff nurse to a 'H' grade senior sister. Nine of the participants held 'G' grade posts. Although only four of these practitioners worked as community nurses, this reflected the clinical experience of the student cohort. Indeed, one of the difficulties experienced at this stage of the research was that the majority of community practitioners had very little experience of students in the branch programme. The demographic profile also represented a range in the amount of professional experience accumulated by the practitioner in their current post. This ranged from less than one year, to more than five years, with the greatest numbers of participants having between one and two years. Although an equally wide range of professional qualifications was demonstrated, the academic qualifications were much more limited; only one participant had a degree, two held the diploma in nursing and one further participant had a certificate in education. The remaining 13

participants had no experience of higher education.

The context of practice

The review of the literature identified the significance of the role of the practitioner in facilitating student learning and this issue provided the initial focus for the interview. Although all participants considered they had a role to play in facilitating student learning, their commitment to that role varied. Some reported that they considered student teaching an implicit part of their professional role, whereas others felt they had no choice but to participate in the role. One respondent described her situation thus:

> "I don't think I had any [choice] really. I think my name was put forward....we've got two community practice supervisors.... theres one District Nurse who's, like, refused and they needed four, so my name got put forward".

Other respondents stated that they had been specifically required to participate in student learning.

The title used to describe the role of facilitating the student's learning was mentor in two study centres and practice supervisor in the third. However, when asked to describe their perceptions of these roles, there was little difference in the interpretation of the two terms. Indeed, both mentors and practice supervisors described aspects of their role as teaching students and organising the students' learning experience. However, there was a difference between the staff nurses' and sisters' perceptions of their role in student learning. Sisters described their role as one of co-ordinating student experience and introducing them

to the clinical environment, rather than participating in student teaching.

> "Basically to ensure the student has a Mentor. The idea of of a Mentor is that the student would be able to choose somebody, but I think that impossible in the present climate. They come to the ward and they're allowed a Mentor. its my responsibility to make sure that somebody is suitable....that is updated, you know, can provide the guidance they need. So thats my initial responsibility; obviously to liaise closely with the School and Personal Tutors.

Another Sister specifically reported that she felt it was "unfair" to the students if she worked with them, as they became "nervous". Another difference in the perceptions of practitioners was found between community and hospital staff. Although all the community staff were qualified 'G' graded nurses, they described their major responsibility as one of having direct contact with students and considered teaching particularly important.

The number of students for whom the practitioners had a teaching responsibility was identified as an important issue. Here too, the difference between the hospital and community setting was marked; community practitioners generally had responsibility for only one student at a time. However, practitioners in the hospital settings, frequently had responsiblity for students on the traditional programme, health care assistants, students on the EN/RGN conversion programme, as well as Project 2000 students.

> "We have Project 2000 students. We have BSc students. We have College students that come for day release; they're on the ward at the moment. We have theology students that

> come to the ward, although I don't have responsibility for them. They just spend two or three days. Medical students, we have Social Work students...."

This had implications for the demands made on these practitioners and therefore implications for the quality of the learning experience provided for the students.

Eleven of the 17 practitioners had completed the English National Board 998 course [Teaching and Assessing in clinical areas]; the remaining six had responsibility for teaching and assessing students, but had not undertaken the course. Although practitioners acknowledged the possible value of the ENB998 course, the need for more general guidance to recognise and use learning opportunities and to be aware of a teaching role was also identified.

Practitioners characterised their own preparation for Project 2000 courses in despairing terms; "too little too late", "no preparation really, only half a day on learning contracts". However, here too, the analyses of these data revealed the important role played by the link teacher in the preparation of practitioners. Link teachers were described as "key members of staff" and where the relationship with the link teacher was described as good, practitioners considered they had a better understanding of the implications of Project 2000 for student learning.

> "As I say, we have a really good liaison with the School of Nursing and our Link Tutor. And if there's any problems at all, we get on the phone to her and she's over here and she'll sort it out. If theres something you're not quite

> sure of in their objectives, she's there. You need someone that you can actually phone across".

However, where practitioners had not experienced any difficulties with student learning, preparation was perceived as less important.

The importance of a link between theory and practice emerged as an issue in respect of practitioners' perception of their preparation for the course; the school was "in cloud cuckoo land expecting the wards to use models of nursing they had never heard of". However, another practitioner reported that they were able to integrate theory and practice and pointed out that "many people feel quite threatened by them [the Project 2000 students]".

Practitioners reported that "they were not always sure what the [Project 2000] training involved". In addition, some were unfamiliar with the learning objectives set for the clinical area and considered they were "pre-set by the school". Other practitioners had developed the use of learning contracts and described these as a "useful method of working on the objectives together with the student". Not all the objectives were considered appropriate by practitioners, particularly those in the community; nursing models were identified within this respect. Several practitioners reported that students needed to set their own objectives in order to integrate theory and practice. However, this raised the issue of the extent to which learning needs identified by the students, reflected those of

practitioners and some concern was expressed that students would not necessarily recognise their own learning needs.

Practitioners were divided about whether their work with Project 2000 students was different from that with conventional nursing students. Some did nothing different; "to be honest I don't think we've changed".

> "Well, I know, personally, that I treat them [Project 2000 students] as I would normal students; you know, the old style student nurse. I feel they get a lot more out of their experience because of that; because they were more involved and they gained in confidence because of it".

Others considered student needs were significantly different. Where practitioners had recognised the need for change, they identified factors such as the need for greater emphasis on practical skills, for more supervision. It was also reported that a concomitant level of stress was of an apparently higher order for students.

> "They're just different, in as much as the Project 2000 girls [sic] can be more knowledgeable and understand the background behind the practical skills, but haven't got the dexterity to carry out, perhaps, an aseptic technique. Once they had done it a few times, they're just as capable as the other learners. But they've identified they have'nt got those skills".

Supernumerary status and the use made of this opportunity by students to plan and achieve their learning needs was identified as a factor which influenced how practitioners worked differently with Project 2000 students. It was also highlighted as a factor which made it easier to learn and gain from their clinical experience. However, confusion surrounding the concept of supernumerary status was apparent amongst practitioners; students

were "not supposed to participate" and therefore "looked so bored". A clearer definition of supernumerary status was called for and practitioners recognised both the need for them to teach basic nursing skills into the Adult Branch and the lack of confidence of students who demonstrated these skills. They reported that Project 2000 students needed more support and guidance than was available.

To this end, the need for link teachers to spend more time in the clinical areas was cited as a factor which practitioners thought would improve the quality of student learning in the practice setting. The need for students to not only spend more time in the practice placement, but also for mentors and students to work together, was identified as equally important. Although supernumerary status was identified as an important factor in student learning, the need for greater understanding by both students and practitioners was also reported.

Relationships in practice

When practitioners were invited to describe their role in student learning in more detail, a range of strategies were identified. One was liaising with the link teachers. The relationship the staff had with a link teacher, influenced their perception of the effectiveness of that role.

> "We don't see a great deal of them. They tend to leave things up to us, because its a specialist area. They think they can't play any great part here; they tend not to come into the Department".

> "We had our meeting as Mentors together and we decided that we would like to meet the Tutors and it was arranged. Now we have regular meetings and we have also arranged to meet the students before they come out to the placements".

Another strategy was identified as teaching students about illness and patients, on either a one-to-one, or group basis. However, this was often done quite formally away from the patients, therefore separating the student from a patient centred learning environment. Indeed, teaching by the bedside, and by example, were described in rather negative terms;

> "Unfortunately, you can't sit down and teach, the way we used to teach. Its got to be by example and the only way by example really is by getting out there and doing"

Other learning strategies were described as setting objectives, working with the student and talking through the students' experiences. Additional functions were identified, which included supporting the student. This was considered an important function; indeed, one practitioner talked about being "a friend to the student". However, strategies were identified that could have either positive and negative implications for the quality of student learning. It was also in the description of the strategies used to facilitate student learning, that the differences between the perception of Sisters and Staff Nurses were demonstrated once again. Sisters not only described their role in terms of student allocation as outlined above, but also in terms of evaluating student learning, particularly evaluating the shift and the general learning experience of students.

The relationship between the role of assessor and facilitator/teacher was also an issue. All except one of the

practitioners reported that they had a role in assessing student performance in the clinical setting. The one participant described a situation where an enrolled nurse could be the student's mentor, but could not assess the student's performance. This situation raised questions about the level of practice demonstrated to the student.

Once more, these data highlighted the role of the link teacher, particularly in relation to reported differences about appropriate learning opportunities. This point was illustrated by one respondent who stated that the ward staff felt the students benefitted by the allocation of patients, but this view was not supported by the School. Another practitioner described "having their wrists slapped" because they had allowed students to leave the ward to observe a procedure:

> "The frustrating thing was that if you're supposed to be learning as much as possible, surely to have a look down someones gastro-intestinal tract would help their anatomy and physiology, as well you know".

Assessment of practice

All the practitioners who participated in the assessment role, described it as appropriate to their role of facilitating student learning. However, there were particular issues in the process of assessing students which were considered important by the participants.

> "It [assessment] is very long-winded and you have to allocate a long period of time to do it. There is so much of it you have to put 'Not seen', 'Not observed', 'Not assessed', because you haven't"

Indeed, these data highlighted problems of assessing students

with whom the named mentor had had very little contact in practice areas, problems of inappropriate assessment criteria and the problem of the different levels of assessed performance achieved by students. Practitioners described strategies they had developed to overcome these difficulties and the use of team work in the assessment process was clearly identified. The role of the link teacher was also considered important where clinical staff had experienced difficulties in relation to the level of assessment of clinical performance.

> "Once the assessment form has been completed, they take them off to their tutor and their tutor will make comments. Occasionally, the tutor will come back to us and talk to us about it if a specific problem has arisen in the assessment. Somebody may have graded a student down and not said why. Same as if you grade a student up, you have to say why".

Practitioners described the use of "gut reaction" in the assessment process, which highlighted the subjective nature of the assessment process and the inadequacy of practitioner preparation, for their different roles in the facilitation of student learning.

Models of good practice

Many of the factors previously described were also identified when practitioners were asked to identify criteria which contributed to excellence in the practice learning environment. Factors such as an appropriate use of students supernumerary status; a staff commitment to teaching; students who worked regularly with their identified practitioner; link teachers who had close contact with the practice area; well planned student learning experiences; practitioners with sufficient time to spend

with students, a capacity to be supportive and a good team spirit were highlighted. These were all identified by practitioners as influential criteria for good student learning; achieving them was a separate matter.

Summary

Within institutional settings, different roles in facilitating student learning emerged for staff nurses and Sisters/Charge Nurses. Whereas staff nurses were involved in facilitating specific learning opportunities and in acting as role models, Sisters/Charge nurses described a role of coordinating and evaluating students experiences within the practice setting. Differences were also apparent when the experience of community practitioners was compared with those in institutional settings. Here, the number of students for whom the practitioner held responsibility emerged as an important factor. Practitioners in institutional settings reported feeling overwhelmed by the competing demands of 'mentoring' students and providing patient care, and suggested that this impacted on the quality of the learning experience they were able to provide.

The amount of contact and nature of relationships with link tutors, was variable. Practitioners valued more contact with tutorial staff and argued that students would also benefit if tutors spent more time in placement areas. Practitioners felt that the assessment of student's practice was appropriately their responsibility, but would appreciate clearer guidance on the

level of practice to be achieved. They suggested that the Link Tutor could appropriately provide such guidance. A clearer definition of supernumerary status was also called for.

The preparation which practitioners received was universally perceived as inadequate, particularly in relation to the amount of information gleaned in advance about the structure and content of the Project 2000 course. Linked to this lack of preparation, practitioners perceived a gap between the theoretical aspects of the course and the realities of practice.

Stage: 1
Branch: Adult
Respondents: Tutors [n=17]

Summary of respondent characteristics:

Sex		Age					Ethnicity	
M	F	24-29	30-34	35-39	40-44	55-59	White	Other
1	16	4	5	4	3	1	17	0

A total of seventeen tutors were interviewed during Stage I of the study and each had had between one and ten years in post. Seven were non-graduates, while three others were studying for a first degree. A further four tutors were studying for a Masters degree. A summary of other characteristics of the tutors interviewed, is shown in Appendix 11.

The Context of Practice

All of the tutors identified that they had responsibilities for linking with at least one, and sometimes two clinical areas. However, not all of these clinical areas provided practice placements for Project 2000 students at the time of the interview. Two tutors had not had experience of supporting Adult Branch students in their designated clinical areas, but had had experience of students placed during the Common Foundation Programme. Most of the tutors interviewed were linked with ward areas. Only two had link responsibility with community practice settings.

Most tutors felt that their own preparation for supporting students in practice settings had been inadequate. In

particular, they felt that they lacked an overview of the course which would have enabled them to help students make links between theory and practice. Almost all respondents reported that preparation had been rushed and had concentrated on the theoretical aspects of the course, with little attention to preparation of practice settings. Several suggested that any amount of preparation would have been inadequate and that it was a question of "learning as we go".

The tutors identified a wide-range of formal courses aimed at preparing practitioners for their roles in supporting Project 2000 students. These ranged from the six-week community practice teachers course, through the ENB Course 997/998, to specific courses in the assessment and supervision of Project 2000 students, usually lasting between two and four days. However, it was the view of most of the tutors, that these courses did not adequately prepare practitioners for the reality of supervising and supporting Project 2000 students in practice. Nearly all link tutors had attempted to supplement formal courses of preparation, with informal sessions covering the content of the course and, in particular, making staff familiar with the assessment documentation. However, the problem of keeping track of all staff within a practice setting was highlighted; "information should have cascaded, but hasn't". Several tutors also commented that practitioners seemed unable, or unwilling, to make preparation for the mentorship role a priority. For some, this appeared to be linked to the students' supernumerary status.

"Because they're not getting a pair of hands from Project 2000 students, they make preparation a low priority".

The multiple and competing demands on practitioners time were also acknowledged. Nearly all the tutors reported that practitioners were overburdened with students and that practice settings required an increase in staff numbers, in order to adequately supervise Project 2000 students. Several mentioned that the practitioners themselves required support, in order to maintain their motivation. At the same time, tutors suggested that practitioners should become involved in the course [given time, so to do] and be prepared to take responsibility for the major changes taking place within nurse education. In particular, practitioners should be enabled to demonstrate more awareness of the P2K course.

The successful integration of theory and practice was a key aim for these tutors and lack of knowledge, on the part of both tutors and practitioners was identified as a major barrier to it's achievement:-

"I'm out of my depth with things that have changed".

"Most of the ward staff don't know what Roy's model is".

"Supervisors theory is not wonderful, but students would be letting the side down to acknowledge this".

Students' status within practice settings also emerged as a key issue with tutors perceiving some confusion on the part of practitioners in relation to their interpretation of supernumerary status. They reported, for example, a lack of clarity regarding the extent to which students could be involved

in checking drugs. In some cases, the tutors themselves were unclear about the acitivities in which the students should appropriately engage:-

> "Whether they should be going off and doing all these things, I don't know".

Tutors felt that students needed to be reminded of their supernumerary status and that they were not 'pairs of hands'. They also reported a tendency for students to sacrifice their supernumerary status and 'get on with the work' in order to be accepted within the ward team; for example, on occasion, students gave up their meal breaks, in order to 'get the work done'.

In a structural sense, more than half the tutors considered that the Common Foundation Programme should be shortened and that students should spend more time in practice settings, and less time in College. Most tutors also advocated longer placement periods within each practice setting.

Relationships in Practice

In describing their own role within practice settings, most tutors identified a function to provide information to practitioners in relation to educational developments and described a pathfinding role in preparing areas for Project 2000 placements. Some tutors saw problem-solving as one of their responsibilities; being available when staff, or students, were unsure about how to deal with particular situations. A monitoring role was also decribed:

"I visit towards the end of the placement to check that the assessment has been completed".

Other tutors identified a role to audit clinical areas to make sure that they were suitable for use as student placement areas. However, this auditing role appeared to be in contradiction to the lack of influence which most tutors felt they could bring to bear on clinical practice within each placement area: "To be able to change things, you have got to be part of the ward team". The majority of tutors suggested that they had to adopt a 'softly-softly' approach, in order to maintain goodwill and cooperation in relation to student placements. For example, two tutors felt that they were seen as a threat by practitioners;

"I don't interfere too much with the practical side".

"I would hate the ward staff to think I'm interfering".

The level of involvement with the clinical area varied considerably with the degree to which tutors felt accepted by ward staff emerging as a crucial factor. To some extent, the changes in pre-registration education, in particular the students' supernumerary status, had altered the relationship between tutors and practitioners;

"We are there for a limited amount of time and can only mop up what they want us to mop up".

"You have to pull yourself back from being a member of the team and getting on with whatever has to be done".

"We have lost our sense of power. People are falling over backwards not to rock the boat".

There appeared to be a degree of confusion over the most appropriate role for tutors to adopt and an awareness that they might not be meeting the expectations of practitioners in their

designated practice areas.

> "I feel as if they don't think I'm doing my job; that I should make the beds".

Tutors' descriptions of what they did with students to help them learn during practice placements varied considerably between settings. Some tutors described working with students for part of a shift, taking over responsibility for the student's learning from the designated practitioner. Working with students seemed to involve both demonstration; "I act as a role model", and observation to offer students feedback on their performance; "Its observing them in particular skills and moving them on to the next thing they want to achieve".

Others felt that to work clinically with students, was no longer the most appropriate use of their time and described how they rather spent time to help students 'reflect' on what they had done. Some tutors suggested that what they did to help students learn would be negotiated individually, which was indicative of a student-centred approach. Most made use of written objectives for each placement, both to identify appropriate learning opportunities for students and to evaluate their experiences.

A number of tutors felt that the students' supernumerary status gave them more flexibility in arranging learning opportunities:

> "I have the power to take them when I want to; take them away from doing things".

In some respects, it appeared that the tutors' 'outsider' status was beneficial in helping students to get the most out of an

individual placement;

> "It's easier to be critical of care as an outsider; you can highlight deficiencies in care to the student".

For some tutors, these deficiencies in care meant that they felt they had no alternative, but to give 'hands on care' with the students;

> "I don't think we can not work with the students, because of the awful things that happen".

> "I spend very little time demonstrating clinical procedures, but that may be a mistake. I watched a student doing a dressing the other day and I had to take over".

About half the tutors interviewed expressed concern that students were 'picking up bad habits' and are not being taught to apply basic principles to practice. Three tutors suggested that practitioners do not have the necessary skills to integrate theory and practice and that it requires a third party [namely, the link tutor] to work with practitioners and students, in order for integration to occur. In some ways, difficulties in enabling students to make use of what they are learning in College, appeared to be linked with the tutors' expression of impotence to move practice forward within designated link areas:

> "Care plans on the ward reflect the medical model and I'm seeing the Project 2000 students doing it the same way".

> "The trained staff do not do care plans well".

> "We can't leave the new students in their hands; things won't change for them either".

There appeared to be a sense of 'powerlessness' amongst the tutors to prevent students from becoming socialised into the existing ward culture and to perpetuate what they felt to be, at times, inappropriate practice.

All tutors identified the practitioner allocated specifically to the student as the prime person involved in facilitating the students learning within a setting, usually termed the 'mentor', or 'practice supervisor'. However, the way in which this role operated varied between centres and between practice placements within centres. In two of the three centres, the mentor also acted as the main assessor; however within the third centre, these functions were separated between two practitioners. In the latter, it was possible for a second level nurse to act as 'mentor', but the assessor was required to be a first level nurse. In some practice placements, two mentors were allocated to increase the likelihood that the student would be able to work with a mentor.

Assessment of Practice

Nearly all of the tutors suggested that the designated person(s) would act as a role model for the student. Most also suggested that their role would involve work with the student and then their assessment when they were competent to perform certain skills. A majority of the tutors reported that they were only peripherally involved in the assessment of Adult Branch students; discussion of each student's progress with practitioners and the offer to become more involved if problems arose. Most were happy with this arrangement and felt it was appropriate for the practitioner, who spent most time with the student, to carry out the assessment;

"They [practitioners] are the ones who are there all the time. Students could put on a wonderful performance for me".

However, three tutors expressed a need to be more involved in the assessment process;

"There should be an area where I can assess their knowledge and how they've applied theory to practice".

"We are very odd in nursing. We say things aren't right in the ward areas, but we will let the people who run those ward areas assess our students".

Tutors perceived some confusion amongst practitioners as to the level of practice which students were expected to achieve and objectives and criteria were felt to be unrealistic in some cases; viz an expectation that a student would be able to teach a skill to another, at the end of the first branch placement. There was also a suggestion that assessment documentation was not altogether clear and that, on occasion, assessors misinterpreted the criteria.

Models of Good Practice

Tutors were asked what they felt worked particularly well about the current arrangements for student learning in their particular placement area. They were also asked to identify features which created a good learning environment in practice areas. Aspects of the student's experience which were thought to work well included;

"Patient-oriented discussion in a clinical setting".

"Getting students to reflect on what they have done".

"Reviewing the rationale for care".

"Using situations that come up to integrate theory and practice".

"Being able to have access to students, without feeling that they have other things to do".

"Getting students to use tools; eg, models in the ward area, goal setting.

The features of a positive learning environment, reported by tutors, included those with a lack of hierarchy amongst practitioners, those where students were encouraged to ask questions and those where staff held a positive view of Project 2000. The development of the lecturer practitioner role was mentioned as a strategy for the creation of a good learning environment, as was the identification of practitioners, within each setting, to have a specific responsibility for teaching students.

Tutors suggested that teaching in practice settings should be more patient-centred and that patients should be 'followed through', during a stay in hospital and after discharge. Patient-based tutorials and case presentations were also suggested as a way forward. However, strategies for evaluating practice were notably absent in practice settings in the view of many tutors;

"What about summarising our nursing; criticising our own practice?".

"We don't talk to each other enough about our practice".

Summary

A variety of roles for the link tutor emerged both within and

between settings. The amount of time spent by link tutors in practice settings varied considerably and different tutors engaged in different activities in relation to the link role. Link tutors, thus, lacked a clearly defined role and struggled to create a role for themselves which practice-based staff would not find threatening. They felt that they were able to make very little impact on standards of care within a designated area.

Tutors perceived a role in preparing practitioners to adequately support and supervise students, but encountered a number of barriers to this process of preparation, not least their own workload. Their own knowledge about the theoretical content of the course was fragmented and this limited their ability to help students to link theory with experienced practice. There was also confusion about the meaning and significance of supernumerary status and the rights which this afforded the link tutor in relation to directing student learning activities. Tutors also expressed uncertainty about the level of practice which students were expected to achieve.

Tutors reported that the assessment of students' practice was appropriately the responsibility of their designated practitioner within the practice placement. However, a significant minority felt that tutors should make a greater contribution to the process of assessment. Several tutors were of the opinion that practitioners lacked the prerequisite knowledge and skills to help the student make links between theory and practice and that,

in this respect, the 'mentor' system was inadequate to meet all the students needs.

Positive practice learning environments for Project 2000 students were regarded as those where students were encouraged to question, where teaching was patient-centred and learning was student-centred.

Stage: 1
Branch: Mental Health
Respondents: Students [n=23]

Summary of respondent characteristics:

Sex		Age					Ethnicity	
M	F	18-23	24-29	30-34	35-39	40-44	White	Other
16	7	4	13	4	2	0	20	3

Qualifications [highest gained]

'O' Level	'A' Level	Degree
12	6	5

Of the twenty three mental health branch students interviewed, five gained admission to a Project 2000 course through the 'DC' Test [see Appendix 12]. Five students [all located at one centre] were graduates. None had entered the course as a school leaver and most had had previous work experience, many in commerce [banking, accountancy, Civil Service].

Context of practice

In general terms, across all three main study centres, students had mixed feelings about their experience of their respective courses to date. Of those who reported enjoying the course, all [without exception] tempered their remarks with accounts of "poor administration and communication, especially between tutors and staff", "awful confusion" and "deplorable organisation".

> "We're all suffering. All the tutors are now after their degrees, so they're taking lumps out [of the course]"

> "Its all a bit haphazard. Things don't seem to get sorted out until the last minute. It makes you wonder just how much they got together. It makes you think 'this is so obvious, why wasn't it thought about?'".

Among those for whom feelings were not mixed, all at one centre, their unanimous experience of the course was as a "shambles".

> "I like the words and the ideology that Project 2000 talks about, but I haven't really found them to be true in practice".

Mental Health Branch students reported such sentiments about the Common Foundation Programme in particular. Almost without exception the CFP was experienced as being "extremely biased toward general nursing".

> "I felt a bit annoyed. What I thought was very unfair was that we weren't being prepared, towards the end of the Common Foundation Programme, for what I was actually wanting to do. I wouldn't have minded to have done general, because I felt more prepared for the general. I was really frightened about going to do psychiatry, because I had nothing to do with it.

> "I felt that the course hadn't prepared me at all for Mental Health. It was a view being voiced by a number of students. I think it was because of the General bias in the CFP, because most of the people who taught us in the CFP were General Tutors. I think this is where it came from. Because of the way I was feeling, I actually said 'I want out. This is my career I am talking about. I want to switch'. I was actually told that there was no position in the General [Adult] Branch. So I either did the Psychiatric, or I left the course".

In a relative sense, therefore, the Branch was "like a breath of fresh air". However, in an absolute sense, the transition from CFP to Branch was not without student concerns.

> "We've lost out, because we've got to start now. Whereas the others [Adult students] will have had three years General training."

> "The Foundation didn't prepare me for the Mental Health Branch, personally. I can't comment on the others, they say themselves the same thing, but for me personally I wasn't ready. The ENB [English National Board] have visited and I have tried to explain this to them...they've been twice already. They listened and they said that was the thing they were hearing from other schools. I could have coped better in a General Hospital...I don't know anything about mental health really.

"We're fitting 3 years work on the RMN, into eighteen months".

"Its like starting from scratch."

Having arrived in the Branch, students reported a range of early experiences including those related to the theory/practice balance, the community/hospital balance, the preparedness of practitioners and the practical experience of supernumerary status.

"The academic requirements are too much, it should be more skills-based"

"There seems to be no rationale behind the input in the course. Like, we had initial things on the skills we would need at the beginning of the transition [to the Branch]. But in the meantime, we had that mixed in with peripheral issues like public policy and psychology lectures on memory. OK, that's important, but that's really not going to help you at the very beginning of a course, when you're actually starting to work with clients for the very first time; when you actually need skills. It just seems to be so blindingly obvious, I really find that staggering".

"Not [enjoying the Branch] at the moment, particularly. I just look at it that all the College days are little oases in the desert. When you come in [to College] with everybody else, like you're verified then....Whereas, because it is different to what they've [practitioners] experienced before, the shift system and the supernumerary status seems to hang heavily with them. 'I'm up at 7am, why aren't you up at 7am?', that sort of approach".

Relationships in practice

In the CFP, in all three centres, arrangements had been made for a practitioner to be formally identified to help students learn in practice areas. Generally, these were known as Mentors. Students reported that short placement periods, coupled with the shift system, with staff sickness and holidays, meant that there were times when "you didn't see a Mentor at all". In the absence

of formally identified practitioners, students "found people to attach to and then stick with them". This was recognised as "a learning experience" for such practitioners, who felt in a collective "quandary". The student experience of this expediency was to "feel a bit stupid", "spare coggish" and "like a parcel".

Although the title 'Mentor' was common in the CFP across all three centres, the term was often poorly comprehended.

> "Link nurse, or whatever they're called".
>
> "Mentor, or something like that. Well, thats the title my link lecturer gave her [when we met]; 'this is your Mentor, [name]'".
>
> "There's so much jargon on this course; possibly 'link supervisor', or some such title.

A quite subtle observation was reported by one student who confirmed a not uncommon sense of "being mixed up for ages" about different role titles.

> "Maybe I'm misinterpreting it, but I always felt people [Mentors] were worrying for their own position and needing to explain, more than teach. I thought people had a lot of difficulty saying 'I don't know'. There's no big deal about not knowing, you should be able to say you don't know and say 'I will find out' and not be worried about what people think about it. Maybe I have just been unlucky, or whatever, but I have often felt that people could never say 'I don't know'.

In one centre, the title 'Mentor' was carried through from the CFP, as the practitioner identified to help students learn in placement areas. When [for reasons already referred to] the identified Mentor was not available, a so-called 'Associate Mentor' would deputise. Both held identical responsibilities for reportedly "facilitating learning", "monitoring", "supervising", "supporting", "guiding", "role modelling" and "assessing".

On occasion, an Associate Mentor and a [absent] Mentor did not share a common understanding of what was required in relation to the assessment of a students practice. In one incident, such difficulty was compounded by an Associate Mentor also being the students Ward Manager. At the time of the assessment, the student was involved in whistleblowing on the conduct of another qualified member of ward staff. In this circumstance, and in the absence of a Mentor, the student expected the support of the Associate Mentor. In fact, the student was "rebuffed" by the Associate Mentor who reverted to a Ward Manager role, which left the student unsupported [except for student colleagues]. When the Mentor returned to work, the students permission was sought to take the matter forward. This was given.

Self-evidently, these ostensible helping roles were not uniformally understood, nor tidily enacted, nor occupied independently of other demands and interests. This was equally the case in the two other centres, where practitioners performed a similar range of functions as Mentors, but held the titles of Keyworker and/or Supervisor. Here, too, students used these titles with perfunctory conviction..."I don't think the words are used all that much. Its there in the documentation, but, generally speaking, people don't talk using those words [titles]".

> "Initially it took me ages to work out what the roles were. It's only clear in my head now. Really, to be honest, I had a very bad time with my clinical supervisor, because she didn't seem to know what sort of input they have. It seems that they only have a couple of days training what their role will be".

In an important respect, a difference existed between Mentors, Keyworkers and Supervisors in relation to assessment of student practice. In one centre, it was the Mentors who assessed in the Branch. In another, it was the Supervisors who assessed, while in the third [where practitioners also occupied the roles of Mentor and Clinical Supervisor] it was the Keyworkers who assessed. Such differences, in part, reflected different organisational arrangements, which themselves were indicative of different conceptual frameworks. Details of these different arrangements are accounted later in this document.

Assessment of practice

In all three settings, the process of assessment actively involved the students self-assessment of their practice, in relation to items listed in the Bondy Assessment Schedule. Thereafter, the Assessor made a second set of judgements and discrepancies between the two 'scores' were discussed and then reconciled. Students recognised that the measurement of practice was problematic and that many of the Bondy dimensions were ambiguous and subject to considerable subjective variation. So, too, there was an uncertainty about the educational level at which the assessment of practice was set.

Students reported examples where assessment judgements of their practice were made in the absence of any witness of it. In such circumstances, assessment was based on the relative strength of student articulation of their unobserved practice.

> "At the end of the day, there would be ways of getting round what was, on paper, a weak area [of practice]. Its my belief, at present, that it is virtually impossible to fail the practical part of the course."

Students in one centre avoided falling prey to the "enormous lottery", which was the assessment procedure, by understanding the need to find the "right" Keyworker, through whom caseload clientele were recruited and from whom assessment judgements were required.

> "So far, I've been fortunate enough to find [Keyworkers who were] 'soft touches'. Thats not for the long term benefit of my educational development on the course. But it is definitely worth finding somebody who understands the limitations of the course and is prepared to compensate for that".

For some students in a different centre, it was known that even 'playing the game' above was unnecessary to ensure that an assessment of practice was passed.

> "We did a twelve week placement, two and a half days a week, and I know people who never went in, yet still passed their Bondy. And it is still happening. It will always happen. Some people actually finished this Term and were starting Term 8 and hadn't even completed the Bondy for the last Term. They would go back and complete the Bondy and still pass it. They would go out there one afternoon, see the staff there, go through the Bondy and pass it. I won't say names, but its common knowledge".

Tutorial staff were universally reported to play an insignificant role in the assessment of students practice. All students were, however, visited by members of the tutorial staff in placement areas. Such visits were usually pre-arranged with students, though not always, and the perception of their usefulness varied.

> "Some tutors tell you beforehand [of a visit]. My Tutor just turned up out of the blue. You know he'll turn up; you just don't know when".

> "We spend time together, just talking really. 'Any problems?'. 'How are you getting on?'. 'Were you happy with your learning needs?'. It varied in the [Mental Health] Branch. In the General [Adult Branch] people actually come up and show you things. But you can't do that on psychiatric, because a tutor can't just walk in and say 'Take this one out and do something with them'. So its hard for them [tutors]. I don't always have them [visits]. I say 'I will contact you when I need you', because I feel its a waste of time, because there not really much they can help me with; apart from if I have a problem. But they are having difficulty finding their role".

Even tutorial staff working from the same institution had different modi operandi. These ranged from a "five minutes, 'how are you?', then go", to "making himself available every Friday afternoon as a resource person". Elsewhere, the focus of tutorial time in placement areas concentrated on the provision of support to the practitioners. In one centre, which had adopted a client allocation model for learning in the Branch in favour of a conventional placement arrangement, each of the eight students would be identified with one Clinical Supervisor and at least eight Keyworkers. Students recognised the magnitude of the task for tutorial staff to make sufficient visits of a meaningful length and frequency, given those conditions.

In general terms, tutorial staff were reported by students as not having undertaken any clinical teaching in placement areas, nor any intentional role modelling; "thats for Mentors and Ward Staff". Reports of a generally welcome "supporting" role for tutors was widespread, however, especially when trouble-shooting problems, difficulties or misunderstandings. On such occasions,

visiting Tutors would be called upon by students to "explain", "clarify" and "reassure" them about their practical experience. For some this meant "talking about feelings", while more commonly this activity was orientated around a discussion of the Bondy assessment booklet and learning objectives.

All students, without exception, were familiar with the learning objectives. Similarly, while many of the learning objectives were achievable, there was almost complete unanimity among students that some were "unrealistic", "over-ambitious" and, on occasion, "a bit ridiculous". In part, such sentiments were indicative of several factors; "limited time in placement area", suspect inter-rater reliability ["tutors mark differently"], an uncertainty about educational level ["the problem is that nobody can justify where Diploma level is"] and imprecise wording.

> "Theres one [learning objective] that says 'organises the care environment' and another that says 'co-ordinates the care environment'. To me, they are very similar. If you're not doing one, then you're not doing the other. So why not put it into one? The classic was 'advanced empathy'. No one seems to know what it is. A few Tutors do; not all of them, actually. I'm still finding it hard to explain that one to Mentors".

Supernumerary status

While in practice settings, students held supernumerary status and each articulated that this meant "not being counted as part of the numbers", or "not an employee of the Health Authority", or "following a programme which is educationally led". Beyond this, however, being supernumerary meant a range of things, including a symbolic notion of being "outside the Team". For

some, being such allowed a freedom to "do our business without having to worry about staffing" or to "have a day off, because you're not being relied on", or "not to make beds", or to "do drug rounds".

> "Project 2000 students cause problems for themselves, by this supernumerary status. A lot turn up at 12 o'clock and leave at 2. Thats their day. An awful lot of them abuse their supernumerary rights. They just don't turn up. That annoys a lot of staff".

For others, 'being outside' was an unwelcome position because it "meant that you were not really part of things". This was regretted by most who acknowledged the comparatively short periods of time were spent in placement areas, in which it was crucial to engage practice issues for skill development. In such circumstances, supernumerary status was "almost an irrelevance"; it "meant very little in practice", or it meant "whatever you want it to mean", including "absolutely nothing".

> "You want to be seen as part of the Team. You don't want to use your [supernumerary] status."

> "Yes, I can see the advantages from the point of view in that you're not tied to a ward as a pair of hands. I can see that. But, at the moment, because of the particular type of course I'm doing, because of the particular state of the course I'm in, I'm supernumerary. But since I'm only in places for one day at a time, here and there, it doesn't actually mean anything. If I was rostered one day a week here, there and everywhere, what would the difference be? Materially, nothing at all, I don't think".

Some students observed differences in the meaning of supernumerary status between the CFP and the Branch. Yet others, between general and psychiatric nursing settings [given earlier findings reported here, the two sets of differences may actually be one and the same].

> "Its [supernumerary status] meant there are times when, if people say 'will you do this?', I can say 'no, I'm sorry, I don't want to do this menial task, washing this patient, or whatever, there is something else I want to go over and do'. I had very great difficulty in the General placements, in the CFP, maintaining that supernumerary status, because there was an expectation that because we were the first Project 2000 students, they didn't really know what to expect. They were used to having students who were pairs of hands. Having been a Nursing Assistant, it was very easy to fall back into that N/A role".

When in clinical settings in the Mental Health Branch, most students expressed a tentativeness in being able to use in placement areas, what they were learning in the College. Common difficulties for this were related to the limited opportunity to practise [because the time in placement areas was so short and/or discontinuous], a lack of experiential skills-based input and a lack of relevant and timely theoretical insights upon which to reflect and test, in vivo.

> "In the CFP, I found a lot of the theory [taught] used General nursing examples of how to apply it. You've got to really think about it on your own, to work out 'how can I apply this to psychiatry?'"

> "I am sure I have done many things wrong, but nobody has ever pointed these out. But, then, nobody has ever commended me either"

For the student immediately above, apparently learning in vacuo without reference points, the remedy for her lack of confidence was to suggest a structural change to the programme; a shorter CFP and a two-year Branch, with traditional placements. Such a suggestion, to either alter the balance or to lengthen the course, was not uncommon amongst Mental Health Branch students. This because, independent of the organisational arrangement of their local course, most students reported an apprehension about their level of skill development. Students were divided about

whether responsibility for this lay with themselves, with the practitioners, or with their tutors. If it were shared between them, a clarification of onus was desired.

Summary

Students who were undertaking the Mental Health Branch in the three Centres of the study, expressed a generalised disappointment with their experience, particularly in the CFP. In part, this experience was related to the awkwardness of the arrangements with practitioners who were formally identified to help them learn in practical placement areas and this percolated into their early experience of the Branch. These helping roles were variously entitled and were not uniformally understood, nor tidely enacted, nor occupied independently of competing demands.

The assessment of practice was reported by students to have been a very uncertain matter, in which members of the tutorial staff played a comparatively insignificant role. Students recognised that the limited tutorial time in practical placement areas was itself shared with practitioners, to whom a support service was attempted. While the magnitude of delivering such a service was also recognised, it was much valued by students.

Supernumerary status held a variety of interpretations both for students and for those who were responsible for their learning in placement areas. In practical terms, supernumerary status was often traded-off against the welcome opportunity to engage actual

nursing. This, because the time students spent in placement areas was widely regarded as too short and/or discontinuous. As a result, most students were apprehensive about their level of mental health nursing skill development.

Stage: 1
Branch: Mental Health
Respondents: Practitioners [n=20]

Summary of respondent characteristics:

Sex		Age				Ethnicity	
M	F	24-29	30-34	35-39	40-44	White	Other
8	12	5	6	3	6	15	5

Of the twenty mental health practitioners interviewed [see Appendix 13], sixteen had been in their present post for 5 years, or less. All, but one, were first level nurses. Each worked in a mental health setting, both in hospital and in the community, all of which were part of the learning circuit for Project 2000 students.

Context of practice

Each practitioner occupied a role in helping P2K students to learn in practice settings. The title of such roles, where they were acknowledged, varied both within and between study centres, and included Mentor, Clinical Supervisor and Keyworker. An understanding of the functions which each implied, varied within titles.

Mental health practitioners who occupied a Mentor title, reported the role to variously involve "being available" to students; "to explore their expectations"; "to make sure they're happy"; "to arrange their programme"; "to provide information"; "facilitate their learning"; "plan objectives", "listen"; "counsel"; "support"; "offer direction"; "allow them [students] to model

themselves on you" and to "assess them".

Many of the features of a Mentor role, were also reported elsewhere in practitioners who acknowledged the title 'Clinical Supervisor' [eg "supporting", "providing security" "assisting the development of students", "organising placements"]. Although many of the functions were identical, the title 'Mentor' was either not recognised, or poorly comprehended.

> "I'm a Mentor, or whatever. No, I'm a Supervisor to recruit a caseload of clients [for a student]".
>
> "I don't think there is a title as such. You're the Assessor for the student. I'm not the Mentor. We haven't identified that, as yet".
>
> " A Supervisor is a glorified Mentor".

Elsewhere, the assessment brief of a Mentor, in one setting, was taken as the responsibility of a Keyworker in another. On occasion, even when the title Clinical Supervisor was clearly acknowledged, it was argued as being wrongly entitled "because I don't have responsibility for directly supervising her [student] clinical work; why its called 'Clinical Supervisor', beats me". The tautology was compounded by some practitioners who were unaware of any title, whatsoever.

All practitioners who occupied such helping positions for Project 2000 students [however they were entitled, or not] were recruited by dint of being First Level nurses, in a clinical area on the training circuit; "I just happened to be here". Most had existing, or previous responsibilities, for the remaining Registered Mental Nurse students "still going through the system"

[both post-registration and initial learners, sometimes referred to as 'our' students], some with Enrolled Nurse Conversion Course students, students on a variety of continuing and specialist nursing courses and on occasion Health Care Assistants.

Relationships in practice

Such a volume of different student groups has not been without a practical consequence, both for practitioners and for clients.

> "There has been a lot of aggro about that [student placements]. RMN students come out [into the community], the conversion course come out and also there was going to be the Project 2000. We would not have been able to cope with that load. So, I think the Team Leader, said 'No'. So, I don't really know what is happening to the students".

> "I had considered falling back on the [UKCC] Code of Conduct; having some regard for how it [student placements] effects me and other colleagues. We should be concerned about that. But I never followed that through. The case would have been that I am actually suffering because there's never a break with students. I suspect, though I don't know, some clients suffer, by not being able to disclose information, because I always have a student with me. And that true to say, because with some clients I actually put subtle pressure on for them to have a student with me. Do you see what I mean?"

> "I think I was more capable than some of the Mentors were, so I thought I'd better do it. There are some dreadful people. There's always dreadful people in every profession".

On the rare occasions when practitioners were able to self-select themselves to be identified in a formal helping role, meeting selection criteria so to do, was a relative choice ["I was chosen in preference to the 'dead wood' staff"], as much as an absolute judgement. Having been identified, many practitioners felt bereft of information and unclear about their role.

"Everyone says 'Oh, you're their Mentor'. But I'm not sure if I really am, or not. I'm the person that they've been placed with. Does that mean I am their Mentor? I don't know. Do I fill all the role, all the bits what the Mentor is meant to be? I'm not sure. I never heard it mentioned at the training course. But I'm none the wiser, to be honest. They didn't seem to know. They didn't answer a lot of my questions. I don't know".

Assessment of practice

Such uncertainty was widespread and became crystalline in relation to the practitioners role in the assessment of students practice. In general terms, practitioners reported the same process of assessment as did the students; viz, students made judgements about their own practical performance according to the Bondy criteria. Thereafter, and apparently independently, practitioners make a second set of judgements using the same criteria. The two resultant sets then formed the basis of a discussion and a moderation of any discrepancies was mutually agreed.

"I am not quite sure how it [assessment of student practice] works. I've yet to have that explained to me. But my student assures me he knows how its done".

Accounts were given of the involvement of tutorial staff to advise or arbitrate in circumstances of contention; "we use the School [of Nursing] to 'trouble shoot'". Otherwise, tutors had not been directly involved in the assessment process in placement areas.

Overarching the issue of process, was the practitioners concern about the educational level of their assessment judgements of student practice.

"I haven't really thought about that [Diploma level] to be honest. As I would understand it, the expectation would be, on a practical level, the standard should certainly be no worse than what it would be for the old RMN"

"I don't know what that [Diploma level] is. I mean, how should I know? I know that it is pitched at a higher level than the training that I did. I know it's pitched at a higher level when training the learners, the RMN learners, that are currently going through. I know that they are doing a different syllabus from the syllabus that I did. So, given all these differences, I don't know for example what ultimately is expected of them at diploma level. No, I don't. I don't at all".

"I guess I've pitched what I do with Project 2000 students at above BTec, but below RMN in terms of what they know".

Many, but not all, practitioners were familiar with the learning objectives for Project 2000 students, though most "hadn't got to grips with it yet". This, in part, was related to the speed with which matters had proceeded; "the assessment document was thrust on us at the last minute, two days before they actually joined us".

Preparation for roles

Almost without exception, practitioners were concerned about the adequacy of their own preparation to help Project 2000 students to learn in practical placement areas; "this is a vital bone of contention". It was common, though far from universal, that preparation amounted to an in-house, two-day workshop and "the odd half day, here and there"; "very itsy-bitsy" and, on occasion, "diabolical". These events were welcomed as a broad commitment from the organisation, though their frequency, length, content and depth were generally disappointing. Some practitioners did not know, what they did not know. Others were

left wanting a greater clarification of their role, greater familiarity with the curriculum, the development of assessment skills; "the whole area of supervision skills has not been addressed". The English National Board course 998 [Teaching, Supervising and Assessing in the Clinical Setting], for which there was "a lot of competition to get on", was variously regarded by course completers as "immensely" helpful, though not sufficient of itself, to "not helpful at all" because it "did not address work with Project 2000 students". It was a rare exception for a practitioner to report a content with the adequacy of their own preparation. Most were discontent and argued the same was the case for the rest of their practitioner colleagues.

Practitioners had little, or no, pre-conceived notion of what helping a Project 2000 student to learn would be like in practice. In part this was because "we were not well prepared and everything was rushed". Others held expectations which turned out to be erroneous, in both directions. There were those who expected a difference between P2K students and conventional RMN students and in practice found that there was none, while others expected P2K students to be like other nursing students and found that they were not. Similarly, because the entry gate to training had remained unchanged, there were those who expected P2K students to be "no different to RMN students" and so it was.

The sense in which practitioners found P2K students to be different was in terms of their level of knowledge and experience

and their visibility.

> "I expected them to be up to speed, and they were not. It is a handicap"
>
> "I thought they would have covered more in [mental health] theory. I haven't found that. Its knocked me for six a bit. I thought I may not be able to keep up with what he already knew".
>
> "I expected them to be around a bit more".
>
> "I think, because of all the hype about nurse training changing, Project 2000 being something completely different from what we've had in the past, there's always been this expectation in your mind, that there's going to be something different expected of you [as practitioner]. And quite rightly, there should be something different expected of me. But what happened in reality, I don't feel that I am offering them anything that is particularly different from the normal student. I don't feel, in any way, that I have been prepared to take on a Project 2000 student that's going to enable me to even look at doing it differently".

Given this, some practitioners "tended to do the same thing" as they had done with previous groups of students.

> "At the moment I don't see any difference. I haven't changed my approach as such. I didn't really feel that there was any need for a change in approach".
>
> "I would say that what I do with Project 2000 students isn't any different to what I would do with 'a student'. What I have got to offer hasn't changed, is what I'm saying. My job hasn't changed, so what I have to offer hasn't changed".

Since less could be assumed by practitioners about the level of knowledge and skill acquired by Project 2000 students in early Branch placement areas, than could be confidently assumed about conventional RMN students [not least because practitioners could draw on their own experience of having had the same training], it ate into precious practical placement time to understand the baseline levels. Eventually, many practitioners regarded these levels, assessed at the two-thirds point into the course, to be

comparatively low, with clear "evidence of basic deficits". This circumstance was, in part, explained by practitioners in terms of the structural context of the course. That is, that students need to spend considerably more time in mental health placement areas. Such a revision was almost universally recommended. Meantime, "we [practitioners] do more, because they [students] have done less".

> "The Project 2000 student I've got is more demanding of me, wanting me to help him with some project he's doing on schizophrenia. But he doesn't know anything about schizophrenia. So its starting from scratch and that is very, very draining. You're driving along in the car, talking about schizophrenia and he's saying 'that's very, very interesting' and taking notes down. I've not experienced that before. It feels as if I'm doing a lecture, from one client to the next. There's absolutely no time for me to reflect on what I'm doing and how I'm working with the clients, because so much is being taken out of me by the student".

> "They're [students] really terrified. They feel that they're not going to come up to standard; that people are going to expect them to do things that they're not able to do. They're really frightened. I think the attitude of the tutors doesn't help. They seem to be rushing off to do Diploma courses and degrees. This was said on the Mentorship course. A large number of tutors feel that they must do a degree, so they're ahead of the students. They feel so threatened by them and I don't know...it just concerns me".

The relationship between practitioners and tutorial staff was unremarkable, insofar as meetings were as rare as were welcome in placement areas. Similarly, practitioner visits to the Colleges were minimal; "I used to teach RMNs in School, but not Project 2000". Even so, a change in expectation was beginning to emerge and clarification was being sought.

> "The school of nursing are looking for us [practitioners] to be the teachers, in a theory sense, as well as in clinical practice"

"I imagine the teaching staff should be leading with their knowledge and enable us to carry out our role. Do you know what I mean? You ask them [tutors] for advice and you get 'Ummms' and 'Ahhhs'. I'm not sure they know either".

Summary

Mental health practitioners in the three study centres, who held responsibility for helping Project 2000 students learn in practical placement areas, had their roles entitled in a variety of ways. These included Mentor, Clinical Supervisor and Keyworker. The functions which comprised each role were numerous and varied between, and within, both settings and centres. Also, some practitioners who held helping responsibilities, were unaware of any title.

The increasing volume of different student groups, including Project 2000 students, had a practical consequence for practitioners and their clients. This was reported as particularly stressful in community settings, where relationships are often one-to-one and unrelenting for long periods of work.

In general terms, the process of student assessment at DipHE level, in practical placement areas, was poorly understood by practitioners. It was in this substantive area that most practitioner/tutor contact [although still comparatively limited] was reported and welcomed by practitioners. A clarification of the division of labour between them, in relation to their respective educational responsibilities when students were away from the Colleges of Nursing, was being sought by practitioners.

Almost without exception, practitioners were concerned about the adequacy of their own preparation, and that of their colleagues, to help Project 2000 students to learn in practical placement areas. The ENB course number 998 [Teaching, Supervising and Assessing in the Clinical Setting] was not widely regarded as helpful in this respect. It was not an uncommon tendency for practitioners to do the same thing with P2K students as they had previously done with Registered Mental Nurse [RMN] students.

Practitioners argued that P2K students needed to spend considerably more time in mental health placement areas. Such a structural revision was almost universally recommended.

Stage: 1
Branch: Mental Health
Respondents: Tutors [N=8]

Summary of respondent characteristics:

Sex		Age					Ethnicity	
M	F	30-34	35-39	40-44	45-49	50-54	White	Other
7	1	0	4	1	2	1	4	4

Of the eight Tutors concerned with the three Mental Health Branch Programmes [Appendix 14], all but one had been in post for five years, or less. Six were non-graduates. Their responsibilities included interviewing and recruiting the students, planning and teaching the mental health components of the CFP and the Mental Health Branch, leading and teaching the Mentor and the Clinical Supervisor courses, running a Mentors Support Group, teaching the ENB 997/998 course, coordinating the progress of specified cohorts of Mental Health Branch students and auditing clinical placement areas. In addition, to these P2K-specific responsibilities, additional commitments included leading and teaching the Enrolled Nurse conversion course, the Diploma in Nursing course, the Diploma in Professional Nursing Studies course and "other post-basic courses".

Context of practice

All had tutorial responsibilities for specified clinical areas and were invariably entitled 'Link Tutor/Lecturer'. These 'link' responsibilities included generalised notions of "liaising", maintaining lines of communication", "giving support", "listening", "dealing with problems", "monitoring progress",

"keeping staff updated", "negotiating placement allocations", "looking at assessment of practice documents", "clarifying the roles [of practitioners]", "helping to achieve objectives" and "anything they want help on"; "a resource person"; "I mentor the Mentors."

In addition to 'link' responsibilities, which were administered mainly to practitioners in particular clinical settings, but also to students placed at such, many tutors carried a 'Personal Tutor' brief, either for individual tutees, or discrete student cohorts which was independent of setting. The difference between 'link' functions and 'personal' functions was unexplicit, other than the context in which they were sometimes performed. Personal tutorship was characterised by a pastoral function to individual students. Tutorial time was not only negotiated for its absolute merit, but also relative to other available options for help and assistance.

> "Sometimes students feel threatened to go to the Mentors, if they are not happy about something. They may see that there might be some repercussions; that people [practitioners] might victimise them, perhaps. That's the reason why they come to us [tutors]".

Such an explanation for student/tutor contact remained at the level of speculation, but was grounded in this Tutor's previous experience of conventional RMN preparation. However, although other Tutor's did not volunteer similar accounts, in general terms tutorial staff reported the present arrangements for student contact in clinical areas as "not at all satisfactory".

Relationships in practice

The unsatisfactory nature was, in large measure, related to the lack of the time for tutors to be actively involved with student learning away from the educational Institution; "unless there's a problem, I don't get involved".

> "In practice, there is insufficient time available to me, to carry out the role in the way I would wish it to be carried out. I would prefer to be able to spend rather more time here [placement area], so that I am more overtly facilitating the students learning. For example, I don't have time to do meaningful clinical work with students. I don't have time to engage in any, say, live supervision with them. I think, given my professional background, I could do that. But I don't have time".

> "I try to meet them [personal tutees] on a fortnightly basis. As I say, 'I try'. It hasn't really worked out at times because of other things happening".

> "We have got some difficulty in living up to our obligations to the standard that is required. My view is that we don't go there [clinical areas] often enough, because of classroom commitments, because of the meetings, marking papers, because of so many other things that's going on".

> "At the moment, I am doing my MSc and its no joke, trying to study and prepare for the sessions as well".

> "I don't do anything practical".

Almost without exception, tutors wished for more of their time in placement areas. For one this would involve a "tutorial base in a clinical setting; for credibility and updating, to bridge the gap between theory and practice". Another "would like a caseload" for the same purpose. Not only were there time constraints on tutors time, but that which was available was often not coincident with students availability in placement areas. Students experience in placement areas was lamented for its "lack of continuity" and "bitty" nature.

"What happens with them, is that students come into the block at the start of the Branch and what we try to do is to give them RMN training in eighteen months. As far as I can see, we're trying to ram everything that we would have given them [RMN students] into eighteen months".

"Theoretical input sometimes follows the practical experience".

"They are shoved from pillar to post, in very short placements. They are never given the time to become a member of a team. They never belong anywhere. So I think they feel quite isolated. A lot of them are probably very scared and quite anxious. I never really get time to settle and resolve all those issues".

Assessment of practice

Such experience had a relevance for the eventual assessment process. None of the tutorial staff reported a direct role in the assessment of students practice in placement areas; this, it was said, was the function of the practitioners who occupied either Mentor, Supervisor, or Keyworker roles. Such roles as tutors did occupy in the assessment process were "minor", "tentative", "advisory" and "supportive".

"I don't get involved with the day-to-day stuff, but I will see the students on their own at least once during the clinical placement. Bear in mind, they are in College every week as well. So I will be checking, 'how are you getting on?', 'any problems with the clients?', 'any problems with your key worker' 'No. Its OK', or whatever".

"If there are problems in relation to the assessments, then I, as Link Lecturer there, will be the person that the practitioners as well as students, would have to come to. It is not a direct assessment [I would make, but I would] act as an 'arbiter', if things are not working well".

For Tutors at one study centre, such a vicarious role was unrelated to the new demands of Project 2000.

"We [tutors] haven't assessed for a while now. Even in the latter stages of the RMN courses, we found ourselves not so clinically involved".

In such circumstances, and with the clear implication for the basis of teaching set innocently aside, a risk of de-skilling tutorial staff for assessment activity was reported.

> "The last time I was involved directly with practice was in 1987 [four years ago]"

> "I haven't had the practical clinical experience. I may have the academic knowledge, but in practice...It was unfair on the students and ourselves to make [assessment] judgements, when we were not au fait with the latest".

As a quid pro quo, tutors reported that not all practitioners would have a "command of the knowledge base" to be "familiar with the student applying the details of psychology, sociology, biology to mental health". An indication of the appropriateness of such individual practitioners, to be formally identified to help students learn in practical placement areas, fell outside the audit activity undertaken by tutors in one study centre.

> "In the Branch, we're [tutors] talking about a personal audit. Now, I think there's some tension within that, because it puts people on the spot. At the moment I don't have a format, or a framework, to say 'Yes, I've ticked all the boxes for that Keyworker'. The only measure at the moment is that they've attended a Keyworkers study day. There's a weakness there".

> "[The audit] merely looks at the physical environment and not the educational environment. It makes me look like a policeman and it doesn't serve any useful purpose, I believe. I'll quote you what one Ward Sister said to me; 'if you're doing a mini audit, that OK. But I have a Trust audit, a Purchaser audit, a Quality audit, and an Instant audit, and then you say you want to do an educational audit? I would rather not be in training [circuit] if I have to have a full education audit'. Until this College designs a bolt-on, which will actually bolt on properly to one of the other audits, then I can't take it seriously I'm afraid".

> "I audit and find flaws. I still require a placement. Service managers know that. And nothing happens. There are no changes, despite the fact that its been printed out clearly; that I've pointed out that things need to be

changed. But actually, the chance of things being changed is remote".

Such an account provided a subtle insight into the power relation between education and service, at a time when [as was reported elsewhere] "there are too many students and not enough placements". Moreover, in a third location, "rostered service is a source of extreme concern at the moment".

> "The Trust is being very, very particular in demanding their 1000 hours from their percentage of students. Although we thought we had a very sound argument and produced figures....the newly appointed boss of the Mental Health part of the Trust is giving us very clear messages, that he wants to see where he can put students on shifts, in clinical areas, on wards, so he can plan to move Health Care Assistants. That is a major bone of contention at the moment, which I understand is still unresolved".

Elsewhere, "we are finding that qualified staff numbers are depleting; this could be linked-up with the running down of the hospital services, but also vacancies over a period of time have not been filled".

Preparation for roles

While the adequacy of the preparation of practitioners was an uncertain matter for some tutors, the nature of their own preparation was more definite; "we did not have time to prepare ourselves, we are preparing ourselves as we go along".

> "We were too busy writing the curriculum for submission [to the ENB] for approval. And once it got approval, we had to implement it".

> "I wasn't prepared [for work with Project 2000 students]. We wanted to get on the bandwagon. It was very speedily implemented".

> "It would have been helpful to have stopped taking basic [RMN] students and to start taking a serious look at what we were going to do, why we were going to do it and what

people's roles would be. We needed time to breathe....instead of getting what I actually think is a Mickey Mouse curriculum together, which was really thrown together really rapidly. I'm amazed it got approval, I can remember the day before it had to go up for approval, being in this room here with bits of paper on the floor, re-writing objectives and trying to consolidate our objectives to bring the numbers down. It was like a circus here, and nobody really believed that it would possibly be accepted. And it was. I don't believe it".

Following the implementation of Project 2000, within a time frame which was universally regarded as unrealistically tight, it was reported that the onus had changed to the support of DipHE students, to ensure their successful participation in the programme. This had been problematic and, for the tutor reported below, had not only cast doubt upon the methods of assessment, but had also pervaded the morale of tutors in their work with Project 2000 students.

"I think it was a political thing. Its like....I'll probably lose my job....I'm aware that students aren't achieving as well as they should within a science perspective examinations and other summative examinations. I'm also aware that the marks have been upped. On one, every student got a 5% increase and that, therefore, reduced their fail rate by a substantial number. Now I think its just political. P2000 has got to work, come what may. The fact is that we're devaluing the Diploma at the end of the day. It will be valueless because we're goi to have so many people going through who are not actua , haven't actually cracked it as they should have. Then it devalues it. Nothing to do with the tutors. They mark the papers honestly. Those papers are marked and put in [to the exam committee]. There was evidence there would be quite a large failure rate. And there wasn't. It was let out of the bag, that they'd been tampering with the marks. They'd gone up. Its very difficult now. Its very difficult to explain what's happening".

Beyond some uncertainty about the level at which a students written work was examined, was both the level at which tutors taught and the level adopted for the assessment of students practice.

"Funny, we don't have anyone [tutors] here who has taught at Diploma level",

"I'd like to think that I am teaching at Diploma level, but I've got no feedback to say I am, or not".

"I think we have a very clear perception of what Diploma level is in academic terms. I don't even think we've looked at it properly in terms of skills. If you said to me 'what's the difference between Diploma level skills in communication or, I don't know, any skill really', I couldn't give you that answer. And I've not had any inkling, or any training, or heard anyone actually give it any thought. And I really don't think we've addressed that issue at all".

As one Tutor put it succinctly, "the clinical people, the clinicians, see us as the experts. But we are nowhere near expert". The lineage was confirmed as "the students look to practitioners, the practitioners look to tutors and the tutors are looking for someone themselves. Its a dilemma".

Summary

Tutors interviewed in this study described a variety of functions which comprised their 'link' roles with service areas. Such roles were not clearly defined and the arrangements for contact with students was, in general terms, unsatisfactory. In large measure, this was attributable to a lack of disposable time for tutors to spend with students in practical placement areas, to bridge the gap between theory and practice.

Tutors lamented the brief and discontinuous nature of the students experience in practical placement areas and the implication this had for the assessment of their practice. None of the tutors had a direct role in such assessments, other than

of a minor nature, which were largely the responsibility of practitioners. Tutors remarked on the uncertain adequacy of practitioners so to do. However, tutors were also uncertain about the nature of their own preparation to support P2K students, which they reported had been compromised by the unrealistically tight time frame in which Project 2000 courses had been introduced. Some tutors had not taught at DipHE level before and felt bereft of feedback and guidance about such.

Summary of key points derived from interviews [Stage 1]

Respondent characteristics [n=115]
[Students n=53; Practitioners n=37; Tutors n=25]

	Sex		Age [yrs]									Ethnicity	
	M	F	18-23	24-29	30-34	35-39	40-44	45-49	50-54	55+	*	White	Other
S. Ad	9	21	20	4	2	3	1	0	0	0	0	28	2
S. MH	16	7	4	13	4	2	0	0	0	0	0	20	3
	25	28	24	17	6	5	1	0	0	0	0	48	5
P. Ad	1	16	0	4	4	3	3	0	0	1	2	17	0
P. MH	8	12	0	5	6	3	6	0	0	0	0	15	5
	9	28	0	9	10	6	9	0	0	1	2	32	5
T. Ad	1	16	0	4	5	4	3	0	0	1	0	17	0
T. MH	7	1	0	0	0	4	1	2	1	0	0	4	4
	8	17	0	4	5	8	4	2	1	1	0	21	4
Tot	42	73	24	30	21	19	14	2	1	2	2	101	14

Legend:
M = Male; F = Female; * = Missing data
S. = Students; P. = Practitioners; T. = Tutors
Ad = Adult Branch; MH = Mental Health Branch; Tot = Totals

The following list of items were key issues which were raised and explored in interviews with students, practitioners and tutors in three Project 2000 course centres in England.

Adult Branch key points:

-Students valued the help provided by practitioners and regarded the relationship with them as an important factor in learning.

-Mentors who were regarded as 'good' by students, were well informed and understood their role in the practice learning environment.

-The tutors role was less significant to students away from College, than the mentor role.

-Students welcomed teaching which was patient-centred and orientated around individual learning needs.

-Students valued highly the practice experience and were universally concerned about the limited opportunities for such. They were particularly concerned that their supernumerary status should not prevent them from engaging in practical nursing activity.

-The assessment of practice by practitioners often lacked relevance, validity and objectivity.

-Different roles were occupied, and their functions enacted, by different members of qualified nursing staff, in different settings.

-Practitioners were overwhelmed by competing demands on their time and this impacted on the quality of the learning experiences provided to students.

-The amount and nature of the contact between practitioners and tutors was variable. The practitioners argued the case for more tutorial time to be spend in the practice areas.

-The preparation which practitioners received was universally regarded as inadequate.

-Practitioners argued for greater guidance about the level of student practice to be achieved. Such guidance would also be welcomed by members of the tutorial staff.

-A clearer definition of student supernumerary status was called for by both practitioners and tutors.

-Tutors lacked a clearly defined role in practice settings and their ability to help students link theory with practice was limited. However, although they regarded this as an appropriate function of practitioners, several tutors were unconvinced that the 'mentor system' was adequate to meet all student needs.

Mental Health Branch key points

-Students expressed a general disappointment with their Project 2000 course experience, particularly in the CFP but also into the Branch, which was almost universally regarded as biased toward general nursing.

-The roles held by practitioners to help with student learning varied within and between settings, were not uniformly understood, nor tidily enacted, nor occupied independent of competing demands.

-The assessment of student practice was an uncertain matter, in which tutors played a comparatively insignificant role.

-Although the logistics involved for tutors to provide a support service to both practitioners and students was understood, this was much valued by both groups.

-The notion of supernumerary status was not uniquely interpreted in practice areas and students traded-off any licence it was thought to bestow, in order to engage actual nursing.

-The amount of time that students spent in placement areas was widely regarded as too short and discontinuous. A structural revision to the courses was almost universally recommended.

-Most students were apprehensive about their level of mental health skill development.

-The increasing volume of student groups placed stressful demands on practitioners, particularly in community settings where relationships were often one-to-one and unrelenting for long periods of work.

-The process of student assessment at DipHE level, in practical placement areas was poorly understood by practitioners and a clarification of the division of labour with tutors in this regard was sought.

-Practitioners were concerned about the adequacy of their own preparation to help Project 2000 students learn nursing in practice areas. The ENB course number 998 was not widely regarded as helpful in this respect.

-It was not uncommon for practitioners to do the same thing with P2K students, as they had previously done with Registered Mental Nurses [RMN] students.

-Tutors reported a variety of functions which comprised their 'link' roles with service areas. Such roles were not clearly defined.

-A lack of disposable time for tutors to help students make connections between theory and practice, in practical placement areas, was regarded as unsatisfactory.

-Tutors lamented the disproportionately brief amount of time that students had in practical placement areas and the implication this had for the assessment of their practice.

-The uncertain adequacy of practitioners to make assessment judgements about student practice, at DipHE level, was remarked upon by tutors. However, tutors were also uncertain about the nature of their own preparation. Some had not taught at DipHE level before and felt bereft of feedback and guidance.

-Tutors reported that their own preparation had been compromised by the unrealistically tight time frame in which Project 2000 had been introduced.

The foregoing items, derived from the Stage 1 of the study, helped to throw light on the pre-specified research interests of the English National Board. It was self-evident that most of the issues were common to both Branches. Indeed, other than a discernably different level of content amongst Mental Health Branch students about the general nursing bias, in broad terms, the issues raised from both were almost entirely synchronous. In sum, these were related to the relationships between practitioners and tutors; practitioner preparation; supernumerary status; theory/practice linkage; assessment of practice and the nature of the supervisory relationship.

Thus, in accordance with the methodological design and the Project Aims, the issues above derived from Stage 1 of the study were explored and developed for a deeper understanding of the substantive areas in Stage 2. Six case studies were undertaken to provide a multi-perspective account of the real life experiences of those intimately involved with P2K student learning in practical placement settings, drawing upon multiple data sources.

The sequence in which the following six Case Studies have been reported, will begin with three which were related to student learning in the Adult Branch, followed by three related to the Mental Health Branch.

Stage: 2
Branch: Adult
Case Study: Centre A

The College was the result of an amalgamation of two Schools of Nursing in neighbouring towns and had retained these sites. Students were mainly placed in the two General Hospitals on the same two sites as the College. The hospitals were a NHS District General Hospital and a County hospital within the same Health Authority. There was a distinction between the two College sites. This was evidenced by the students being divided into two groups on different sites for the Common Foundation Programme [CFP] and by being placed [mostly] in the associated hospital and wearing the uniform of that hospital, in all clinical placements. Indeed, the students were quite clear about which site they 'belonged' to, even into the Branch.

The two ward areas chosen for study were from the two different sites. They were very similar environments. Both areas were mixed orthopaedic wards, separated into bays of four or five patients. Both areas practised primary nursing and allocated students to a primary nurse as their mentor and assessor, with the associate nurse as their secondary mentor. This situation allowed the student both continuity of patient care and continuity of clinical support, for the duration of their placement. Both areas had CFP and Branch students, at different times, and both described their staffing levels as sufficient, in the absence of the students. This gave the students the opportunity to be supernumerary in the placements. However, in one area the Sister

described the staffing as "bottom heavy", since Project 2000 had started. Prior to P2K, she usually had four students in her area, some of whom would be in their third year, and these had been replaced by one health care assistant. She felt she needed more staff nurses, but had been offered more health care assistants.

The community data focused on a student placed with a District Nurse who worked from a National Health Service General Practitioner practice in the centre of a market town, close to one College site. The District Nurse was responsible for a team of nurses and all the patients on the practice list, although a second District Nurse team worked from the same setting. The District Nurse involved in the present study was not the nurse to whom the student had been allocated for her placement; she had taken responsibility for her because the students mentor was absent. This situation caused some difficulty for the mentor; "I'm a bit startled really, because she's not my student and I don't know what [her mentor] has planned for her, or done with her". When asked about the day which the researcher had observed, she commented further;

> "I haven't done any formal teaching today. I might have done, but I don't know what she has done with [her mentor]. I hope she might have picked up things from what she's seen, but I haven't actually taught her anything formally".

The District Nurses who worked from the practice each had their own desk and there were spare desks for other members of the team. They had the use of a separate room for teaching, counselling and meetings with other members of the primary health care team.

In the two ward areas, there was a difference between the Sisters in respect of their attitude towards the needs of the students in that placement. In the first setting, the Sister described the whole allocation as;

> "Pre-planned; to provide visits to fracture clinic, physio, hydro, OT, plus opportunities for unplanned visits. Also planned weekly teaching sessions plus impromptu sessions at any convenient time from all the ward staff".

In contrast, the second Sister reported that P2000 students were sent a ward-devised learning programme prior to the start of their placement. However, there was no formal teaching in the area; "they are here to learn the practical side. It's too easy for them [for the ward to provide formal learning occasions]".

The students in both ward settings had a designated mentor who was known to them and with whom they had worked for the majority of their time in the placement. For one student this was true for both observation days and for the other she spent a day with her primary mentor and the other with her equally well known secondary mentor. The first day included a substantial amount of student directed learning and the difference in the two days reflected the differences in the style of each mentor. The student in the community was disadvantaged by being with someone who was not responsible for her during her placement, in the absence of her mentor. However, this person was not unfamiliar to her and she appeared to feel at ease to ask questions of this practitioner as she worked. She did not identify this as a barrier to her learning.

All three students in this centre described their relationship with their mentor as comfortable and good, despite apprehensions in one case at the start of the placement. This student explained;

> "I am quite comfortable with [mentor name]. Well, I am now. But I didn't know her then, but now working with her quite alot over the last couple of days .... it's just getting to know her....getting to know her personality, the way she looks at people and values people, the way she nurses. It's all important, I think. It sort of creates an impression a proper impression. When I first saw her, I wasn't sure what to expect. I had heard a few things from my colleague who had her as a mentor and I just thought 'I have to just suss it out myself. And now, after two weeks, I am quite comfortable. I like her".

All the mentors valued having a student who was enthusiastic and eager to learn, someone who was interested and they all described their present students this way. A District Nurse made the difference explicit when she described a good student; "She was very eager to learn and she sparked something off in me, I was very happy to teach her". However, a poor student was also described; "It was just a lack of interest there, nothing to do with me. I tried".

It was also important to the students that their mentors were interested in teaching them. A student was asked what worked well for her learning.

> "I like enthusiasm, I like a bit of umph. When someone drones on and on....I haven't lost interest, but I would probably would learn more on my own, than I would from that individual. It's how they are, how they deliver their stuff. Just how open they are to questions and comments and things like that".

Working with a primary nurse gave students both continuity of patient care and continuity of supervision. Students valued this.

The relationships each had with their mentor were good and reflected the mutual trust that had been developed though working with a defined group of patients together. In other centres, the concept of supernumerary status and the consequent change in the student role caused difficulties for clinical staff and this was passed onto the students. This was not so in this centre. The two ward based students valued the freedom which they had, through not being part of the service team;

> "If I had a choice between giving out dinners and to go and see a change of dressing, I would go and see the change of dressing; [supernumerary status] gives me that choice".

The organisation of primary nursing in each ward differed and, with this, the contact students had with other ward staff. In the setting where the primary nurse had patients located alongside other nurses patients, there was an expectation that all staff responded to patient calls. It was not possible to tell which bell was ringing and it was not acceptable to respond and then say 'Ohh, it's not my patient'. In this situation, the student expressed dissatisfaction at being supernumerary, because she felt it excluded her from being part of the ward team. In the other setting, however, the patients for whom the primary nurse was responsible, were all located in a discrete unit. The student, here, felt the ward staff had a good understanding of her supernumerary status and felt at ease within the whole team. This student captured the essence of this and confirmed;

> "You don't feel the pressure that you have to constantly work and please people, to be looking like you are working, that concept where nurses look busy all the time".

In the community, practitioners have primary nurse status, by

dint of working with a defined caseload. The student here also enjoyed the freedom supernumerary status gave her, but in a very different way. Students in the wards defined freedom as not being relied on for service; this student saw it as allowing her to participate in service. The support of her mentor here was essential, but the nature of the arrangements were uncertain;

> "I am not sure of the students role in the community. Are they just to take a passive role? Are they here just to observe? I think the level of participation depends on the student and the guidelines laid down by School in the assessment documents. I take my cues from the students. If they seem confident and willing to help, want to do things, then I let them. Today, I wasn't sure about letting the student do that dressing alone. It might have been too early on in her training.....but I knew from talking to [mentor name] that because we've been extremely busy lately, she had done things like that before. And the student was confident, but not over confident. Some people might think that it was too early; that she shouldn't have gone out and done that alone. It depends on the student, it really does; how they come over to you".

It was apparent that the clinical areas had authority over the students learning in placements. This was evident again by mentors who made their own judgements over the extent of a student participation in practice. They also made decisions about when students were in clinical areas. Although one setting allowed students to decide their shifts, ultimately students deferred to the wards wishes, in all areas. The difficulty centered on the difference of the ward areas, that worked to a seven day week and students were expected to follow this.

> "I have kids and I have to fit in around them. You can change your shifts, but they don't make it that easy and it causes such a rumpus, that I tend to just work what I'm put down for; unless it's really impossible".

Both Ward Sisters intimated that there was a burden on their staff being responsible for students and made the learners aware

that they expected something in return;

> "I tell the students when they arrive 'you can help us by taking part in the work and then your mentor will have more time to teach you'. It's give and take".

The difficulties mentors had to balance service responsibilities concurrently with a teaching comittment were apparent and universal. The learning occasions observed in all areas were constantly interrupted by the mentors who were distracted to deal with patient care and other demands on their time. On one occasion, a student was observed having been left in the middle of an aseptic technique for ten minutes, unable to continue whilst the mentor responded to an interruption. This and the need for more time to teach, were recognised as barriers to learning by both Mentors and students alike.

All practice areas were linked to the School through a specific tutor. Ostensibly, this was for the students benefit, although the importance of their contact with ward staff was also reported. Here too, the tutors described their role as being someone for the clinical areas, and the students, to call upon if there were difficulties. All reported that the new course had made substantial additional demands on their finite time and that the consequence of this meant a loss of time available to them to visit clinical areas. However, it was reported that this had been a gradual change over the last few years. Their role had changed from one where they expected to help students learn practice in clinical areas, to one of being available for support, in which no time with students in their placements was

planned. This change had been noticed in practice areas and, with it, a need for tutor contact was identified across all areas.

> "The tutors haven't visited the students in the community. I was telling the student she should do 'this, that and the other', but she [link tutor] hasn't been to the placement and seen the situation. I was saying one thing and the tutor was saying another and the poor girl [student] was finding it very difficult. We met up and tried to talk it out".

> "I think it would be quite good for the students if they [tutors] saw her more often....but then they see her every week in School. With the old RGN students, that used to be one of the biggest complaints, because we never saw a teacher in the ward....because they felt they weren't getting any practical input from the School, they were just getting it from us. I shouldn't say 'input'; I suppose, more support, than anything. But now they [students] are spending one day a week in School and that is much more than the old students got. They wouldn't see a teacher from one week to the next.

> "I don't know [what I would have a tutor do, if one visited], to be quite honest. I think, sometimes, it's just nice if they come up and just say 'Hello, how are you getting on?', to the students, or to us. Maybe talk to the mentor and the student together, but not necessarily to do anything, as such. To show there is some connection between the School and us. Sometimes I think the two are quite separate. The School is over there and they do their bit and we are over here and we do ours".

One tutor had divided her role into two distinct parts, which she shared with a new unqualified tutor in the College;

> "We have an excellent relationship with [link tutor name] and she has a deputy who visits the ward more in the old type clinical tutor role. She comes and works with the students at least twice during the allocation and they are always there at the end of the phone if we want them .... we've known her [link tutor] for years. [Concerning the deputy] we felt it was necessary, that they should see somebody from their tutor line during their allocation here and it actually works well. For instance, if she comes in in the morning and they are not busy, she actually takes them off and goes through X-Rays with them, which we might not actually have time to do"

The deputy referred to above was the only School-based person observed in the practice areas and she worked exactly in the

manner reported. The student conceded that it was a good learning occasion;

> "It was awful because she asks so many questions. That was quite useful though, she is very good at teaching the whys and wherefores".

There were numerous examples of patient centred teaching during the periods of non-participant observation, particularly in the ward areas. Most of this was student initiated, and particularly valued, by the students.

> "It's better with the patient and the information. It's much more interesting, it makes me more interested to learn. When you are in School you just take it down as notes and keep it for exams and things like that. You can't imagine trying to relate it to a condition like, for example, total hip replacement. You know the hip and you know the femur, but you haven't got the patient there and you don't know how it is going to affect their mobility and the pain.... here, you can actually see them and it makes more sense, really".

The students in all the settings were questioning in their practice. They repeatedly engaged the mentors in conversation about what they were doing and the area in which they were working. This was the impetus for most of the teaching, on all observed days, in all areas, and practitioners recognised the importance of their role in helping students to use their knowledge in practice;

> "I don't always think necessarily that theory relates to practice. Although they have the theory, sometimes it bears no relation to practice, to the situation, especially the acute practice. They don't understand why .....I feel that is something I can help with".

There were frequent examples of this. One mentor particularly questioned the students knowledge as a matter of course, before giving new information and the student was able to feel that she had something to contribute and her learning was appropriate to

her knowledge and experience.

In all areas, it was the mentor who assessed the students and this was observed in one placement area. All reported they took account of the views of other staff who had worked with the student, but since the students were able to spend so much time working with the primary nurse, this was not as important as in other centres. All mentors considered the assessment document to be very long and in-depth. One identified a difference in the Project 2000 students, by the way she is expected to assess them;

> "It's harder to assess these [P2K] students. I would have to check the nitty gritty stuff of orthopaedic wards with the old students, but now I have to assess these students more on the nursing skills they have developed. It is more about their practice, than what they know".

Although it was not possible to capture observational data in relation to the assessment of students in the community setting, the two ward settings had opposite views concerning the Project 2000 students level of practice. In one area, the practitioners did not believe there was any difference in the way students were assessed in their practice now, but that the Project 2000 students did not reach a similar level to the traditional students; there were concerns in this area about the students abilities once qualified. In contrast, staff in the second area believed the new assessment to have been quite different. Both the mentor and Sister felt this reflected the different practice of the new students and their different abilities; the tutors also felt this to be so.

Stage: 2
Branch: Adult
Case Study: Centre B

Data collection, here, took place in the second term of the Adult Branch, during which students focused upon the nursing care of elderly people both in hospital and community. The term lasted for seventeen weeks with the first two weeks and the final week spent in college. The remaining fourteen weeks were divided between hospital and community placements. Students also attended one study day, in College, each week. The students were supernumerary in practice placement areas.

The settings included of a community health centre, and two wards specialising in care of the elderly. The community setting was a Health Authority clinic on the outskirts of a large city. District Nurses were attached to General Practitioner [GP] practices, but worked within a defined geographical boundary. Two District Nursing teams shared the premises and each combined the skills of a qualified district nurse, a district enrolled nurse and a nursing auxiliary. A staff nurse was also employed on a part-time basis to work between the two teams. Nursing staff shared a large office, but had access to an additional room for teaching/counselling students, approximately eighty per cent of the time. There was also a separate staff room. There was, however, no separate desk and chair for allocated students. A limited range of books and journals were kept at the clinic and the GP surgery. There was also an index file of research articles available to students.

The hospital settings included a fifteen bed, male, care of the elderly ward. Patient care was organised using a system of primary nursing and based upon Roper's activities of daily living. In total, eleven trained staff and nine nursing auxiliaries were employed. Length of patient stay varied considerably according to social circumstances, but was usually between two weeks and six months. The main ward was organised into bays with two separate side-rooms and facilities were assessed by the ward staff to be adequate, although there was no separate room available for teaching students. A teaching folder, together with some books and journals were available to all staff and students and were kept in the Sister's office.

The second hospital setting was a twenty-four bedded, mixed sex ward, which was divided into three bays and four cubicles. Care was organised around a system of team nursing, with patients divided between three teams. However, at the time of the study, the ward Sister had been instructed by her managers to reorganise the ward into two teams, since staffing levels would only allow two trained nurses on duty during day shifts. Students were allocated to a team with their mentor and worked with the same group of patients whenever possible.

In one setting, criteria for teaching and mentoring students appeared less rigid than elsewhere. For example, it was possible for a second level nurse to act as the student's mentor and, although a first level nurse was designated as the student's

assessor, it became obvious that the second level nurse took the major responsibility for completing assessment documentation.

The students in ward settings also reported that it was not uncommon to be allocated to work with a health care assistant for the duration of a shift, particularly if their mentor had responsibility for running the ward. One mentor justified this practice, thus;

> "I know [auxiliary name] quite well and I know her attitude towards the patients. I also know that, if she had any problems with the patients, she would soon tell me".

While the health care assistant's limitations as a teacher were recognised, the student appeared to be fairly happy about the situation. For example, when the Project 2000 student observed the health care assistant performing a dressing, she reported:

> "I mean she [HCA] couldn't answer all my questions, but it was useful to see it done. She appeared to know what she was doing and, I mean, she couldn't answer every question, but, then, no-one knows everything, do they?"

This particular student appeared to value input from all members of the ward team.

> "Some of the HCAs are really knowledgeable and they've been in their job a long time. They really know how to handle patients, better sometimes than a staff nurse".

Mentors were observed to use a range of teaching strategies to help students to learn. In all three settings, mentors highlighted the importance of negotiating learning objectives with the student; in other words, made their teaching student-centred. This was linked to the continuous assessment of the student's current level of knowledge and the value of this

approach was recognised by students:

> "My last mentor was very good...she always cross-questioned me; everything I did and slightest thing, 'Why why are you doing that? We've just done something and were missing out, 'what was that?'. Although it was quite stressful, it was very good".

> "This ongoing assessment sort of keeps me on the right lines".

Another strategy which appeared to work particularly well for students, was to ask the student's opinion in relation to patient assessment and intervention. There were also numerous examples from the observational data, where mentors appeared to learn or pick up information from students and this reciprocal flow of information was acknowledged by mentors:

> "If you're not sure about something, ask the student. She knows; she's been taught it in School, hopefully.

During one period of observation, the student taught her mentor and a health care assistant how to perform a particular type of lift. This was later confirmed as a significant experience for both student and mentor:

Student: "We were just assessing how to move her [the patient] off the bed and I just thought of using a lift that we've been taught in College...I felt good actually, because, you know, it was quite good that I can teach people to make the job easier for themselves and for the patient...the staff know the basic lifts and, like, my mentor had heard about the lift, but she hadn't, wasn't really sure about doing the lift".

Mentor: "I'd heard about this lift, but never actually put it into practice with somebody. And it does seem ideal, so I learnt something from my student which was good. She was able to teach me something".

There were also examples, particularly within the community setting, of practitioners who encouraged students to relect upon and evaluate experiences:

Mentor: "How did you feel that one went?"

Student: "Well, I felt I was a bit disorganised. I mean, I felt I should have got everything organised before I started".

Mentor: "Yeah. As long as you remember to wash your hands each time. One obvious mistake that you didn't do, your didn't wear...."

Student: "....apron".

The Mentor went on to provide a rationale for wearing an apron for each dressing change.

Although staff within the ward settings recognised the value of patient-centred teaching, this was sometimes difficult to achieve in practice. For example, when asked during debriefing if she had achieved what she wanted to achieve with the student, one mentor replied;

> "I wanted to follow through on the discharge. We tried to do that yesterday, but it wasn't possible. Another patient came up today...but, ideally, I'd like the student to do a complete discharge, not bits of something somebody's prepared in the morning, for going home in the afternoon".

Another mentor recognised that her teaching had been necessarily task-orientated, as a result of other demands upon her;

> "Had there been somebody more senior to me on the ward, I could have worked with [student] all day with the patient. I feel that what I did today, was very much tasks really, rather than actually being with the patient and looking after their basic care".

There was abundant evidence within this centre to support the notion that the relationship between mentor and student influences the student's learning experience within the setting. One ward Sister was quite clear about the nature of this relationship;

"The relationship has to be that the student is not afraid to ask....if the student can not form a relationship with the mentor and they can't agree, or can't get on, then I think, if you can't overcome that, then I would take the student and give them to another mentor. I just feel very strongly that the student should be happy, should be able to communicate, should be able to function effectively and be able to talk freely, give their opinions, suggest change, bring in their research and they shouldn't be afraid to do that".

The student's approach to learning in the practice setting also seemed to be a factor in securing a positive educational experience. All students observed within this Centre appeared enthusiastic and eager to learn and this did not go unnoticed by their mentors:

"It's good when someone responds to you well. You can always tell if someone's not happy working with you, reluctant to do things. This student seems to be interested in working here".

A link tutor narrated an incident in which a District Nurse was initially very reluctant to have a Project 2000 student, but was instructed by his manager that he had no choice. The link tutor told how they had carefully selected the student to be allocated.

"We sent a male student, who was very on the ball, very quick thinking, very keen. The male student was brilliant and turned the District Nurse completely around".

Within this Centre also, there appeared to be some confusion about activities in which students could and could not engage:

"I'm not sure. I don't think that you, as a student, can order drugs. I mean, you could do it and get someone to countersign" [Mentor to student]

"They say, 'Ohh, you're not allowed to lift are you?' and we would say, 'Ohh, yes we are".

Students reported that the College had produced guidelines about what students were able to do at different points in their

training, but seemed unsure about the rationale behind this. One student questioned the need of ward staff to know at exactly what stage they were in their training and felt that this contradicted a student-centred approach. However, another student could not help but compare her own knowledge and skills with students on traditional courses:

> "I get a bit frustrated when I'm not familiar with the drugs and where they are. Maybe because I'm just going into my third year and I just...you compare yourself to the other students who at that stage, you know, know quite a lot".

In community settings, this uncertainty of expectation related particularly to the issue of whether students could visit patients unsupervised. In the setting observed, both mentor and student were quite clear about the benefits of this practice, as long as the student received adequate support:

> "Its an ideal that they will achieve if they are up to it; they will have a caseload. Its not something they must do in order to pass this...but if they feel they're up to it, they do gain a lot out of it. [Mentor]

> "I [student] can get on without close supervision, as I hope I've demonstrated today. But I think its important to have overall supervision, because I havn't got the expertise, or the experience, to deal with every eventuality and, therefore, I have to have somewhere to go to". [Student]

However, the link tutor for this setting recognised the difficulty which allowing students to visit alone caused for some practitioners;

> "We've had some problems with mentors who didn't allow the student to do as much as they felt able to. They are highly qualified and highly paid practitioners and it is sometimes difficult for them to let go. It's making a huge leap for District Nurses". [Link Tutor]

The link tutor's role in helping students to learn varied between practice settings. In the ward settings, both link tutors spent

time working alongside students, ostensibly to assist them to relate theory to practice. One highlighted a responsibility to assist students in applying models of nursing within the practice setting, particularly since practitioners knowledge in this area was limited.

> "They're looking at care in terms of Orem this term. It's essentially a care study based on Orem's model. When I'm working with the students on the ward, I might say 'OK, so you just help me to relax; is that, you know, wholly compensatory, or partially compensatory?' Just try to get them to think in very basic terms. You know, what does this model actually mean and when discussing care, I always try to do it in terms of Orem".

Students at this Centre were required to prepare a case study within each practice placement, using a different model of nursing. Major problems were caused for students to achieve this, particularly when the identified model varied from that used in the practice placement area.

In one setting, both student and link tutor agreed that the link tutor did 'nothing different to the ward staff' in practice settings. However, the link tutor's role in problem solving was acknowledged within all settings.

In the community setting, the link tutor worked differently:

> "We meet with the student and their mentor, go somewhere quiet and talk about the student's progress. I would lead it and lead it through the student, based around competencies; 'how are you getting on?' to the student, then 'how do you feel?' to the mentor. I don't go out with the student to visit patients. I'm taking a broader view. I know what they should know what they've recently covered. I can think about the themes, link it together".

This input was particularly valued by the mentor:

> "Its very important. [Tutor name] comes up at least once for every student that you've got. She goes through and makes sure that you and the student both feel that you are going to be able to meet the criteria for that block. She's very good at helping us to focus on particular areas with the student, which are very relevant to the theory side of Project 2000. One thing about [tutor name], she does realise how much extra work it is".

All three link tutors saw themselves as a resource for the ward staff. This was confirmed by some, but not all, of the practitioners who were interviewed; for example, one Ward Sister reported that she had no contact with the College and would like to spend time with the students, before they came to the ward. This, to gain an awareness of what they had been taught in theory. This point was reiterated by a mentor:

> "It would be nice to have a bit more information on what level they're at, and where they've been, and what they have achieved before they get here".

Despite the perceived lack of preparation on the part of some ward staff, there was evidence that practitioners were able to assist students to relate theory to practice, at least some of the time. The mentor in the community setting, in particular, was observed to make frequent reference to published research and guided the student to find supplementary literature. Ward based tutorials and study days were also important to help students relate theory to practice. However, the integration of theory with practice was not always straight forward.

> "This term has been quite good really. Our study days have really been linked to what we're doing on the wards. It was a bit iffy last term".

An additional function of the Mentor, observed in all three

settings within this Centre, appeared to be to demonstrate the realities of practice to the student. That is, the difficulty of of always applying theoretical principles to the letter:

> "We would normally fill up the holes with paste, but we haven't got any at the moment. So we do the best we can".
>
> "Your aspeptic technique is fine given that you're in the community".

Students felt that they were able to discriminate between 'good' and 'bad' nursing practice and decide for themselves who to use as role models; "You look at them and think, 'I'm never going to be like that', or 'I really want to be like that'. One student reported that she learnt by observation of different staff doing a procedure, "but obviously you will know yourself which one is right". Upon further questioning about how she decided 'which one was right', the student made reference to the policy book and to published research. However, another student found differing practice more problematic:

> "What is difficult, is that different staff have different ways of doing things and sometimes I get contradictory advice and it's a question of box and cox, really; doing it that way, when I'm with someone else. I'm learning from that, because I'm deciding for myself which is best. I usually ask why and, depending on the explanation, decide".

However, for this student the mechanism and rationale for making such decisions remained unclear.

There was an obvious confusion in relation to the level of practice at which students were to be assessed in each setting. Some respondents suggested that students' practice should be assessed at a higher level than of traditional students, some felt that there should be no difference and some argued that

practice should be assessed at a lower level than traditional students, since Project 2000 students had spent much less time in practice settings.

> "They need to be able to demonstrate that they can perform and understand. Its a higher level of practice than RGNs; they need to know the theory underlying why they're doing things. [Community tutor]

> "The traditional nurses were obviously on the ward and putting practical experience with theoretical knowledge on a regular basis. But now the P2K are limited with the practical training, so I think it only fair that the level should be different, really. [Mentor]

> "It's higher [level] in terms of what's expected of application. I think, in terms of clinical competence, doing the job and taking responsibility, it's not. [Tutor]

Written objectives were found, on the whole, not to be useful in indicating an appropriate level of practice:

> "Have you ever seen any of these booklets? I mean the wording is just crap [laughs]. The wording they put in is just not applicable to the question they're asking you. You know, its something like, 'the student can now teach this subject' and it just isn't appropriate.

The community setting was the only setting where there was apparent agreement between the main participants on the level of practice required. This was the only setting where mentor, student and tutor met together to discuss the student's progress.

Here too, the chasm between the ideal and the reality of supernumerary status was apparent in both ward settings;

> "I don't feel we are [supernumerary], because I don't feel the ward could work without us. If they took us away, sometimes I don't think there would be enough actual staff on there. On a number of occasions, we have been counted in the numbers, because I don't see how they could have managed on different shifts without us being there and actually working".

An issue highlighted in discussion with mentors was that,

although the students, held supernumerary status, this luxury was not shared by the mentors and this impacted upon the effectiveness of student learning. If Project 2000 had reduced the tension between 'learning' and 'working' for students, this tension remained and was a source of stress for mentors:

> "Even though they are supernumerary, the staffing levels of the ward affect how much supervision they are given. You can't always take a student, when there's something major going on and explain why you are doing this, because it just wouldn't be practical, it just wouldn't be right for the patient. At the end of the day, we're here for the patients".

Stage: 2
Branch: Adult
Case Study: Centre C

The College of Nursing was based on the main site of a large inner city teaching hospital. At the time of investigation, the hospital had an application for Trust status in progress and this change was felt to be imminent by the staff in all clinical areas. This was identified by practitioners in two settings as a major concern to them and raised insecurities about their future working practices.

The College had amalgamated from a number of schools of nursing and so had three different sites, at some distance from each other. The College placed students in a variety of different hospitals. Two ward settings, on different sites, and one community setting were identified for this stage of the work. Two of the students were supernumerary and one [in a ward placement] was rostered. In all settings, the students were allocated a practice supervisor who was also the students practice assessor. However, only in the community setting was this person someone with whom the student expected to work with on a daily basis. In one ward setting, she was allocated to a team of nurses and in the other the practice supervisor was the Ward Sister. In this situation, both the student and Sister realised that this meant she had commitments other than the student. In the setting where the student was in rostered practice, she did not expect to work with someone on a daily basis.

The first ward setting was a 30 bedded, mixed sex, general medical ward on the same site as the College. The ward was separated into three main areas with a team of nurses for each. This was a new arrangement, which had been set up just prior to the period of observation and, within this, the students were allocated to a team of patients and nurses for the duration of their placement. They were not allocated to a specific mentor, although the Team Leader took responsibility for the assessment of student practice. This setting had a number of facilities for the ward staff including a coffee room and separate teaching room. These were in addition to the facilities provided for patients. There were many learning resources available to all staff and Project 2000 students were given a formal orientation by ward staff to the area when they arrived. There were both Branch and Common Foundation Programme [CFP] students, as well as Registered General Nurse [RGN] students in this area. It was considered by the Sister that the area was staffed sufficiently without the Project 2000 students. However, she did comment that "we would miss the students, because they are an extra pair of hands; but we would manage". The student in this area was supernumerary and had been in the placement for seven weeks, with three remaining. This was her first branch placement.

The second ward setting was in a smaller District Hospital within the same group. This again was an acute general medical ward. The ward was a Nightingale-type, which accepted only female patients. The ward allocated students to patients and this was usually

within a team allocated to half of the ward. The student in this setting was rostered and had been allocated to the Ward Sister as her supervisor and assessor. It was her first rostered placement which she had nearly completed. Because the student was rostered, she was part of the ward staff and, therefore, the ward was not up to staffing levels without her.

The community setting was a fundholding Inner City Health Centre, placed within a different Health Authority to the Teaching Hospital. The focus was on one District Nurse who lead a team of three practitioners of different grades. There were two other District Nurse teams in the same setting. There was some insecurity in the setting due to the imminence of the teams being split to work for two different Community Health Care Trusts.

The facilities in the setting were very limited, with the respondents sharing an office with more than eight other practitioners. All shared three tables and the only secure storage was for client notes. There were no other facilities in the Health Centre for teaching, or meetings. The District Nurse concerned, had supervised Project 2000 students in this setting prior to observation. Indeed, the student had been placed with a different practitioner in this setting during her CFP and had completed a community study during this time. Students were allocated to a District Nurse as their supervisor, although they also worked at times with other members of the team.

The observation period was held during students first and second days in this placement, and the data collection process was interrupted by the respondents sickness. Cognizance should also be taken, in consideration of data presented here, of the difficulty made for the Adult Branch researcher to secure access to a community setting in this centre. Despite early assurances, this was eventually possible only after very considerable re-negotiation. A similar difficulty was faced by the Mental Health Branch researcher, again in the community settings of the same Centre [possible explanations for these difficulties have been accounted by respondents, later in this document].

The absence of the link tutor in the clinical areas studied in this setting, was evident. However, something not observed elsewhere, was the presence of the students' personal tutor in clinical areas. There was confusion over the difference between these two roles of 'link' and 'personal', in all areas. The link tutors identified their role as facilitating the ward staff to help the students to learn, to provide clinical areas with information about both the course and the students educational needs and to be available for call-out if there were difficulties for, or with, the students. They were clear that they did not have a role to teach hands-on care giving, although the practice supervisors expected this from them and were disappointed that the burden of teaching students fell to them. The tutors believed they were there for both the staff and students. This was reiterated by the ward Sisters, but the community practitioner

had a different understanding.

> "No [the link tutor does not visit patients with the student], but she did come and spend a morning with one of the District Nurses. We thought it would be good for her because she had no District Nurse background; to give her an idea of what we do. So we invited her and she took up the offer and enjoyed it. I think [her role in this setting] is more for us [practitioners] really.....she says she is the link tutor for here....unless she is the students personal tutor, she wouldn't be involved with the student.....the students all have personal tutors. No [I never have contact with personal tutors]; if the student didn't turn up in a placement, then I would try to get in contact with her personal tutor....when I ask the students about [the link tutor] they don't know her. The link tutor is really responsible for allocating the students in this placement; organising it".

One student had involved her personal tutor, instead of the link tutor when she had a problem with her placement. She justified this by saying "I know my personal tutor better [than the link tutor]". Such reluctance to involve the link tutor, was echoed by another student who believed the ward staff were in charge of her practice experience. The personal tutor visited the clinical area during the observation period and was introduced to the researcher by the Sister; "This is [personal tutors name], the students mentor". This was the only representative of the College observed in placement areas and she had been asked to visit by the student.

In all settings, all groups of respondents talked of the link tutor being involved if the student had a problem. This seemed to be the one consistent factor in the tutors role.

> "We've got the clinical teacher and I've got quite a good relationship with her. If I'm in any trouble, and I have students here, if I can get hold of her she will come and she'll take over, which is great".

The definition of what was a problem was more difficult. In all the incidents reported when the tutor had been called upon, the situations had reached crisis point. In two incidents, this concerned a student who was not meeting her learning goals and the ward staff were unable to rectify this. The third was on a ward which was so short of staff, the staff simply did not have the cover to provide patient care, let alone supervise dependent students.

The tutors expected to be involved with students who had difficulties, but, in practice, this rarely occured. One tutor explained the situation as she saw it;

> "I think when there is a problem with a Project 2000 student, a student who is finding the course difficult, or not managing, I think they are going to have more problems supervising them than, perhaps, a student on the old training; because it is a little more difficult to identify what the problem is.....those students who do well, will do very well in Project 2000; but those who have difficulties, will really flounder. I think [this] because their learning isn't so rigid. Whereas before, you could get through by doing all the right things and saying the right things to the right people. Now, they have to be confident to do what they know they should be doing, or be able to ask; be more assertive".

There was evidence from both the practitioners and the students in clinical areas, that each was unsure of themselves and the other, in relation to the students role and their learning needs. One student had particular difficulty with this and the following extract of a conversation with her personal tutor makes the situation explicit.

Student "Different people have different types of teaching. Some are not very good at it, some are not actually ready to teach you. They just carry on with what they

are doing, rather than showing you what you are supposed to know. And that's life. You just have to go up behind them and watch what they do. They say 'if you don't mind, would you stop following me?'. I say to them 'I am supposed to be following them to see what they are doing', but they still tell me to stop following them".

Tutor "If you can actually sit down with them and explain to them they are the role model for you and that you are watching how they go about delivering the care. But you also need to have practice at delivering the care yourself, because just watching them...you learn, but you need to actually practice as well".

Student "I think they should know that. I'm not just following them aimlessly. I'm not just following them, for the sake of following them. I'm following them to see what they are doing, and how they are doing it, so that I can get to see the way it is supposed to be done. But they don't see it that way, and that is why I was really, really looking forward to seeing you today".

There were many examples of practice supervisors who had expectations about how students should have behaved in the clinical settings; viz. "It is not nice to ask too much in front of the patients. Just make a note of it and we'll discuss it later". These did not always match with the students own expectations; "Asking the question there and then, I would have got more out of it, because by the time I've come out, I have forgotten". One tutor summed up this situation; "it is as though this is a new animal and they [the ward staff] don't know what to do with them".

The changing role of the students in clinical areas and the difficulty this caused for all concerned was often highlighted. A supervisor identified the difference of the new students by saying they were more independent and questioning than the old students. She elaborated this further;

> "Independent isn't the right word; 'questioning' [is] to an extent, but just not really conforming, I suppose, to the traditional organisation of the ward. It makes the ward sound incredibly regimental when I say that and that we expect them to fit in, but to an extent the ward has to run and the patients have to receive the care and attention that they need. And if the patient has to be in X-Ray at nine, they have to be in X-Ray at nine. It's not what they are not doing. I think it's that they have so little time on the ward. It's more that they don't appreciate the role of the ward, the role of the different members of staff, the doctors, the physios. They don't appreciate the whole hospital setup, the whole organisation as much, and it may be something that is achieved in time, once they are qualified....It [ward] is an organisation and it is run in a specific way. The care you can give can often be changed, but you can't change the organisation unfortunately....I think that can be seen as too much fitting into task orientation, but it isn't. It is giving the patient the appropriate care, at the appropriate time....I don't think you can change the structure of the organisation".

An expression of this changing role in the ward environment was in the students supernumerary status. Being divorced from the necessity to provide service and to have their learning needs placed at the centre of their experience, was the ideal. For the student in the community, there was little question of providing service. Indeed, the practitioner was reluctant for students to work alone at all. This was allowed only after observation of them for some weeks and, even then, dependent on the individual student. The students difficulty in this placement was to gain participation in care giving; she did not participate at all during the two days of non-participant observation, although she made repeated attempts to do so.

The students placed in hospital ward areas had very different experiences. The student who was rostered, was depended on for her service contribution and her learning needs were relegated.

In other settings and Centres, repeated evidence was reported, and observed, in which occasions for student learning were disrupted by competing demands on practice supervisors and mentors to concentrate on service issues. Here was the only setting observed, however, where the occasions for learning were disrupted by competing demands on the student's own time, imposed by the same attention to service matters. This happened relentlessly;

> "I'm trying to think if I actually learnt anything today. Well, how to give two people commodes at the same time! Not being sarcastic though, it's like learning to juggle a load and prioritise and learn what comes first".

The second student was supernumerary and although her experience of this was uncomfortable, she recognised it as a stage she had to go through. All respondents talked of the need to take account of the individual student, when deciding what supernumerary status meant. There was a continuum of interpretation, from simply observing to working alone and this matter was decided by their practice supervisor.

> "There is no reason why the student cannot participate under supervision, but the degree of their participation depends on the practitioners professional judgement".

However, there was a point when students had no choice, but to move on and this was to make the change from supernumerary status to rostered practice. There was a suggestion that students were not always ready for this, although the nature of this change was not always understood by practitioners. A staff nurse reported an incident with one student, who was not ready for rostered practice; "she didn't like to make decisions about care".

> "There are a couple of students who have come [here] and they are Third-Years now. So they are rostered students and I can't imagine that, if they were left in charge of the ward next year, what would happen. I think they would flounder purely because they haven't met situations and that was their first time. The old curriculum students, where they meet a situation several times by the time they are in their third year, it gives you scope for.....say managing a ward. They say 'I'm a third year; I've done all this and I'm now ready to manage the ward on a quiet day. I find that they are not going to have the knowledge that the old students had. I think we need to give more thought to the rostered Project 2000 students, who are really still supernumerary".

Evidence was found of practitioners who valued student learning contracts as a focus for teaching in practice settings and, in two settings, the encouragement of reluctant students to set learning goals. However, in the one setting, where a formal occasion for the evaluation of the students progress was observed, the assessment document appeared to be the sole origin of the student's learning objectives.

In each setting, students were clear about the person who should formally assess them; this was their Practice Supervisor. In reality, the event was both reported and observed to include various members of the ward team. A tutor identified the advantages of this;

> "[being assessed by a variety of people] is inevitable.... and in a way that can work to your advantage. If you are working with different people, and they are assessing you, and they have different emphases on things, in a way you can get a fairer picture....If it was just one person and maybe you had a disagreement, if that person is very good at being fair and not taking disagreements on board, so they are completely objective in their assessment, then they won't take that prejudice into account".

Examples of student-centred learning, aside from the formal

evaluation of students progress, were limited. There were many examples of supervisors who directed students learning, not always in accordance with the students wishes, or, indeed, their interest.

Supervisor "Why don't you do a lifestyle assessment on a patient whilst I do the IV's".

Student "Can I watch you do the IV's?".

Supervisor "I think it's a bit irrelevant at this stage; to do a lifestyle assessment is more appropriate. You need to learn how to do that first".

The students approach to learning in the practice setting was identified as important and did not go unnoticed. For one student, for example, a non-questioning demeanour was a source of criticism from all the staff with whom she worked. One staff nurse described her as "letting them all down" by not being forthcoming and noted this as the students biggest problem in gaining a good learning experience. For the rostered student, it appeared that there was simply not the space for her questions, while the third student had specifically been discouraged from asking questions.

One student particularly seemed reluctant to initiate learning opportunities and preferred to wait and be asked. Her strategy, to notice an occasion in which she wished to be involved, then move over and wait to be included, was not successful. Indeed, it discouraged practitioners from including her. She reported that the presence of the researcher had had a positive influence on the amount of teaching and learning she had received during the observation period and that she had been offered

opportunities from which she had previously been excluded. Her personal tutor had advised her that she "cannot leave the learning to them; it is your responsibility".

Students consistently rated practice-centered teaching as the best learning occasions and prefered this to be patient centered. These patient-centred opportunities were not frequent in this Centre. They ranged from being provided with information about patients in order to put their nursing care into context, to students participation in drug rounds. In this, the drugs were explained, which gave students an understanding of the patients medical condition. Although practitioners identifed these as good learning occasions, generally they reported observation and participation in practice by students as more important learning occasions.

Although the students valued patient-centered teaching, more commonly formal teaching sessions were based around tasks, or medical conditions. This reflected the emphasis on tasks in care giving, in the settings observed. Being trusted to do things, made the students feel valued and therefore more willing to get involved and contribute. A student, who was new in a placement, made repeated attempts to contribute, but slowly became disinterested, as her attempts were rebuffed. Her supervisor never-the-less valued her presence as a means of keeping contact with hospital practice. On a number of occasions she questioned the student on current ward practice, as she gave care in the

community. The rostered student, who received little direct supervision, was relied upon by the Sister to report any difficulties she had. The Sisters confidence in her to do this, allowed her the freedom to get on with her patient care. Another student did not feel valued in any way;

> "I would like to have the experience to do things on my own but I am supernumerary, so I can not be trusted to do anything on my own".

In all settings, there was a belief that the new students did not match the level of practice of traditional students at the same stage in their training. Only the link tutors and one Sister expected the students to reach a similar standard of practice.

There was real concern in one setting about the abilities of the new students upon qualification and their consequent first level practice. This lack of confidence was shared by the student in this setting and made explicit by the Sister;

> "They don't seem to have that knowledge, for some reason. They are learning to be a Third Year in a very short space of time, whereas the old students they were First Years and there was room for them to be babies and make mistakes and be covered and supervised....they had to stand up and find for themselves. They were much more practical and by the time they were Third Years they were ready for management skills, whereas these people [P2K students] have been a long while in College and so really the third year rostered ones are the equivalent of maybe eighteen months/two years in".

Stage: 2
Branch: Mental Health
Case Study: Centre A

Data presented here were captured during June 1992 from multiple sources and based around four separate days of non-participant observation [NPO], in three field settings; one in a psychiatric hospital ward and two situated in different community mental health settings. The NPO time in a hospital was spread over two consecutive days and involved both a morning and an afternoon shift; while in the two community settings, NPO time amounted to whole days in consecutive weeks.

These data were derived from (a) post-hoc accounts of actual experience, provided by three first level nurse practitioners who were responsible for helping a Project 2000 student to learn in each of the three practice placement areas; (b) from the three students of nursing who were engaged in such experience; (c) from two nursing managers who were responsible for the practitioners where the fieldwork took place, together with (d) the Tutor who had link responsibilities for both areas. Data were also drawn from documentary sources provided by the respondents.

The setting in which hospital-based data were derived was a twenty three bedded acute psychiatric admission ward of a large Victorian psychiatric hospital, set in rural surroundings on the outskirts of a large town. The ward catered for a variety of adult inpatients, of both sexes, many of whom were reported to be in crisis and needed professional intervention. On the

occasion of the NPO, the ward was staffed by a 'D' grade Staff Nurse, who had been qualified seven months, supported by two young Nursing Assistants; "the minimum permitted". The staffing level was increased during a second period of observation by an additional Staff Nurse of eighteen months experience. There were three students allocated to the ward; two Project 2000 students and one RMN student; "I don't know what we would do without them". A division of labour between the nurses was on primary nursing lines, but not for 24hr responsibility.

Of the two community settings, one was a Health Centre some fourteen miles from the College campus [one of two] where the Mental Health Branch students were based, in a comparatively small and remote, rural market town. The well established team of Community Psychiatric Nurses [CPNs] who were based there, and shared communal office space, offered an open referral service to a population in a specified geographic area. All qualified community psychiatric nursing staff, who had responsibility for helping P2K students learn while they were placed with them, were each known as an 'Associate Mentor'; this being the counterpart of 'Mentor', the title given to their hospital colleagues. The second community setting was a dis-used cottage hospital, just within the environs of the same large town where the psychiatric hospital was located, where a separate team of community psychiatric nurses had taken up sole occupancy. Here, too, the CPNs accepted referrals from "the world and his wife" in a defined catchment area which swept from the outskirts of the

town, into the surrounding countryside.

The organisational arrangement of the students curriculum while in Mental Health Branch practice placements areas, required them to dedicate 60% of their time in hospital settings and the remaining 40% in community settings. Such an arrangement was the focus for a set of explanations to account for an experience characterised by its "chopping and changing" nature. For town-based students, who were dependant on public transport to travel to these remote rural areas, this was compounded by a time and energy sap from finite resources and opportunities.

Moreover, limited time available either to students because of the logistics of their educational programme, or to practitioners as a consequence of low staffing levels ["I've been told its because of the application for Trust status"] was reported as an important de-limiting factor in student learning. For practitioners, that is, "when push comes to shove, the patients come first" and educational responsibilities were necessarily set aside. This was described by both parties as understandable, but unsatisfactory.

The limited time students spent in practical placement areas, and the context in which that time was spent, percolated into the full exercise of their supernumerary status for several reasons. There was the practical sense, by way of example, in which it would have been difficult for students to disengage from contact

with their practitioners when working in remote community settings "where it worked differently", bound as they were by shared modes of travel and other shared commitments. In such circumstances, the arrangement for learning was essentially personal, indeed "cheek by jowl". Students repeated a general unwillingness to miss an iota of practical experience, since such experience was comparatively brief. Indeed, the restricted way in which supernumerary status could be operationalised by students appeared to be endorsed by the English National Board:

> "The ENB lady that came to visit us recently. She came to ask how we were getting on, etcetera, and we talked about supernumerary status with her. She talked about situations where students had been asking for time to go off and do some studying. She didn't seem to think that was acceptable. I was quite surprised because, to me, there are times during a day on a ward when it is going to be quiet. It might be better helped if you actually go and do some work. I thought she might have respected that". [Student]

There was also the sense in which student supernumerary status was not always wholly embraced by practitioners, who were expected to provide a service to patients with modest, and occasionally "dangerously low", levels of human resource:

> "We initially thought that it [supernumerary status] meant that we would have half an hour, or so, a day where we could go off to a library and study. We did start to do that. But, you got the undercurrent that it wasn't really liked by the staff here, because we should be on the ward". [Student]

Students themselves recognised the modesty of staffing numbers, and therefore felt compromised not to deplete the visibility of nursing staff yet further. An awkwardness thus arose in which students felt obliged not to leave a placement area to engage matters which were 'educationally led', and in which practitioners felt unable to provide the necessary support to

them when they remained.

The subtlety of this stand-off position was not apparently fully understood during a teaching session arranged for students in a community setting:

> "Supernumerary status means being able to spend time with clients. Its nice to have it now, because you're not going to have it when you're trained". [Manager]

For a different Manager, supernumerary status had a range of interpretations and uses:

> "Students feel vulnerable. Students feel reluctant to take initiatives. The trained staff, on the other hand, are reluctant to give them the facility because they feel that they are not supposed to do that. When it suits the students, supernumerary status is fine. But when a task dosn't suit them, then they will hide behind their supernumerary status".

Evidence to this effect was reported by both students and practitioners alike, and a tension was noted. A tutor regarded the actual meaning of student supernumerary status as "a good question". However, while a definition of supernumerary status at its most vapid meant "not being counted in the numbers", the subscript of which was that a contribution to service provision could not therefore be counted upon, the corollary was that it also meant that additional staff were not counted into the numbers to accommodate the demands made by such students to ensure their learning needs were nurtured. In such a fraught working environment, it was not unusual for a student [out of their earshot] to be regarded as burdensome:

> "The Project 2000 student will do the drug round this lunch time; unfortunately. It will take forever. The students knowledge of drugs is very poor". [Practitioner]

Moreover, when the event eventually took place, the call on already stretched resources were further exacerbated by an unexpected admission of a patient. It was apparent that trying to offer instruction in such a pressured climate, professional regard for [say] patient confidentiality was put at risk and, on occasion, betrayed and poor role models established. As a crocodile of patients formed at the drug trolley in a day room, the following exchanges were heard by everybody, including visitors:

Practitioner "What's Chlorpromazine?"
P2K student "Its for schizophrenia".
Practitioner "That's right".

Similarly, in such circumstances, the likelihood for practitioners to recognise and engage learning opportunities for students were put at risk and occasionally lost. When this oversight was coincident with a student whose knowledge was limited, and who had [necessarily] to work alone for much of their time, the matter took on a crucial importance. By way of example, a P2K student was asked by a practitioner to accompany an hallucinated and deluded inpatient to another part of the hospital for an investigation. During the ten minute walk across the grounds, the patient [who was close to tears] talked loudly and angrily about losing a child. On the way back to the ward she asked the P2K student, "I'm not going to commit suicide, am I?". The student did not engage the enquiry. Upon entering the ward, and without a debrief being offered, or invited, the following exchanges were observed:

Student	"OK then?"
Patient	"Am I dead, or alive?"
Student	"He's in quite a bad way with his mood swings, isn't he?
Practitioner	"Yeah. Right, I've got an injection to do [with another patient]; do you want to do it under supervision?"
Student	"OK. I've done one injection standing up, but found it hard to do".
Practitioner	"Never mind. Lets go for it. OK?"

This fragment of data provided an illustration of how, under fraught staffing conditions, the quality of patient care was compromised and how student anxieties and learning opportunities were not addressed. Moreover, the practitioner above, whose self-description was as an "honest, patient and willing" member of staff, who "enjoyed teaching", never-the-less found the constant need to supervise under such conditions, "very irritating at times":

> "I think 'just go away and leave me alone'. I have to try and quell my irritation and maybe send her off on an errand or something, just to give me five minutes breathing space, before I blow my top". [Practitioner]

What this practitioner was unaware of was the student in question recognised the perfunctory nature of the support both from the practice area and the tutorial staff; moreover, was driven to seek outside remedial help.

> "Its very demoralising. A course like this should be building your confidence up. I actually went out to a private tutor, because I got totally demoralised. And it was nice to get some positive feedback. Because I was at a loss in the end as to whether I would get through it [the course]. But since I've gone out, I feel a lot better again. Its building my confidence back up. But I've had to pay to do this and I feel very angry about this...it should have come from the school. I feel very angry, cheated and bitter". [Student]

A teaching session on non-verbal communication to be led by a practitioner, which had been long planned to take place before

the period of NPO was organised, had to be cancelled because of the "staffing level in relation to the business of the ward".

Elsewhere, other students located in community settings "had been lucky", even though the experience of supervision was acknowledged as "very tiring" for both students and practitioners. Community psychiatric nurses reported that they had always to be conscious of a third person [student] for their patients' sake and to be conscious always, for their students sake, of the high levels of emotional trauma from very distressed clients, who lived in otherwise completely ordinary domestic surroundings. Students reported their "luck" in terms of "having a lot of teaching sessions" with CPNs and "one-to-ones, you learn a lot more that way"; debriefing through reflection upon actual clinical experiences was universally welcomed by students [when it happened], independent of context.

In both community settings, an intentional effort was made by CPNs to try and link the theoretical considerations to some practical examples witnessed during the days work. On one occasion this involved setting aside structured time [an hour], in which a CPN delivered a lecture to his P2K student [who sat alone, opposite and just a yard way] about a particularly relevant clinical condition. He read word-for-word from notes he had taken when attending a DipHE course some years before. Though the session was intense and the student a little embarrassed, it was well received and acknowledged to represent a considerable

commitment to the students learning experience.

As was been shown earlier, such commitment was not universal between settings, indeed not even within settings. For, within the setting immediately above, the exceptionally committed practitioner shared an office with an experienced colleague whose orientation was in a completely different direction. For this community psychiatric nurse, Project 2000 students "were about as popular as a fart in a lift" and that any expectation to be instrumental in student learning would be tantamount to "having a dog and barking yourself". The colloquial reference here was to the expected contribution to student learning which was, or should be, made by tutorial staff in practice areas.

Whether this view was shared or not, both students and practitioners had very little contact indeed with tutorial staff; "impossible to get hold of them", "very elusive", "never come into the field -ever". This circumstance was reported without exception and independent of context.

> "I haven't actually seen them [tutors]. I had hoped to because we had an audit of this [area] as a student placement area, about a month ago. And one of the things we said was that students, while they're here, don't have any input from the tutorial staff. One of the outcomes of that was they would make two visits per month to see the students. But that hasn't happened. I haven't heard why". [Practitioner]

Students had recognised that "mentors were frustrated with tutors". In one community setting, practitioners had organised a day for each seconded P2K student to present their project work at a gathering of practitioners under the auspices of the

Team Leader. On reflection, it was thought that the link tutor would have had an interest in attending such an event, but "we haven't asked them, we have just forgotten them really; again, I suppose it just highlights the gap".

Although one manager believed that practitioners had "very close working relationships with tutors" and that they understood the educational level at which assessment judgements were made, the gap in such relationships was more widely regarded as "massive" and partly explained two features of the educational process; the universally poor understanding of the arrangements for the assessment of student practice and the uncertain linkage between theory and practice.

Support for the more sombre interpretation of the two realities was lent a credence by a member of the tutorial staff, who acknowledged that only "six out of thirteen" Mental Health Branch students remained on the course. It was reported that the first cohort of students, then three-quarters of the way through the Project 2000 course, had just submitted a mental health nursing care study [to provide one indication of a students capacity to relate theory to practice]. These had been marked by the relevant tutor who found them to be "appalling; most of them failed".

> "I think that [the students poor performance] reflects, and the whole school says this, that that's because we got the recruitment wrong to start with. Some people are in the [Mental Health] Branch and dropped out, who should never have got that far. I think, I know, and we all know, that the assessment procedures weren't right. We were letting people through, that should never have got through".
>
> [Tutor]

This, too, was widely recognised in the field and articulated by many practitioners who knew for themselves that students "found great difficulty" in linking practice to theory. As one practitioner put it:

> "I think we are being quite unfair on them [students] actually. They need an awful lot more work, remedial work if you like, intensive work, to bring them up to a standard. It would be quite unfair to push them through. They're going to get an awful shock when they qualify, if they qualify. Maybe they're [tutors] so desperate for the course to succeed. I really don't know". [Practitioner]

While students, without exception, argued for longer periods of supervised practice and more tutorial contact ["I've made my views known, so did the group above, but nothing changed"], for one tutor this came as a revelation:

> "Well that's interesting, because I didn't know that students wanted to spend longer periods in placement areas. I'm very discontented about it and some teachers have brought up their discontent. But its interesting; communication does not prevail everywhere. Now, certainly at the end of every term the Course Coordinator of every group does an evaluation and I would like to think that what comes out of that, would be brought to the attention....But it depends who is doing it. You know....some might not pass it on. For example, I teach the psychology on the CFP and I get increasingly irritated that I never get the results of the evaluations. Its beyond me. [Tutor]

Mental health Branch students in this Centre, well into the final year of the Project 2000 course, were openly apprehensive about their relative capacities. There were few reference points to disabuse them of this notion; most of the stakeholders in this educational enterprise were muddling through; doing their best in uncertain and trying circumstances. For one student, the result "felt like being dropped from a plane in France" and most could but agree.

Student "I am not convinced that the training I've had will equip me to work in the community; not even in hospital".

Manager "That's because they've got it wrong with you".

Stage: 2
Branch: Mental Health
Case Study: Centre B

The organisation of the Mental Health Branch Programme at this Centre, was designed around a comparatively rare curriculum model which departed from the conventional arrangement of placing students in particular practical placement areas, to ensure exposure to a set of discreet clinical experiences. Instead, the model required each Project 2000 student to recruit, engage and discharge a small caseload of no more than eight current clients, during the first year of Branch, whose clinical characteristics were able to satisfy pre-specified criteria.

Every client of the Service, whether in hospital or the community, was identified with a Keyworker [akin to a Primary Nurse in other Centres] who acted as the principal contact and/or therapist, during each episode of treatment. Invariably, the Keyworker was a first level nurse. The task for P2K students, therefore, was to locate and recruit their caseload from a sample of these clients, in negotiation with individual Keyworkers. At the moment of recruitment, the Keyworker to the client assumed the same title in relation to the student. Similarly, the term 'client' referred not only to their position in relation to service provision, but also in relation to the students own caseload. The customary notion of a 'practical placement area' was, therefore, not applicable at this Centre.

The potential clients 'available' to P2K students in this way,

were not only resident in their own homes, but also in a variety of mental health care facilities, including several large and remote Victorian psychiatric hospitals. These were situated in disparate settings such as the centre of the host metropolitan City, such as on suburban fringes of the City some five miles distant [where the College of Nursing was based] and in settings upwards of twelve miles beyond, into rural locations.

Data presented here were captured during August 1992 from multiple sources and based around four separate days of non-participant observation [NPO]. As before, these data were derived from post-hoc accounts of actual experience, provided by five first level nurses practitioners who were responsible for helping a Project 2000 student to learn while they worked with individual clients; derived from the three students of nursing who were engaged in such experience, together with a Tutor who had responsibilities for the students concerned. Data were also drawn from documentary sources provided by the respondents.

The context-free nature of the students educational experience in the Mental Health Branch was unusual to those who were faced with the logistics of the model, at an operational level:

> "In principle, yes, I agree with the approach, but I am afraid resources may be the stumbling block. If we don't get the resources, we may well be forced into retracting what we've got and maybe going for a more traditional, safer, familiar [arrangement]. I think that's partly the frustration. We've never had a real opportunity....we've had a token opportunity to go to [Town name] as a one -off. They sold their client allocation model in a very, I felt, Utopian way. And we really didn't get a feel of the

> difficulties. The previous Senior colleague took on the [Town name] model really quite strongly, without really much consultation. Do you see what I mean? He was saying 'Well, here's the model, we're going to use this one'. But the reality on the ground now is 'Aha, I wish I'd known A,B,C and D a year ago', I might have approached it differently'. [Tutor]

Much of the difficulty was related to the low visibility of tutorial staff in the wide range of field work settings, and the impact this had on practitioner support and student learning. The over-arching issue was the number and complexity of the relationships which had to be acknowledged to "keep track" of the shape of students experience. The mathematics involved multiplying each cohort of [say] six Mental Health Branch students by the number of clients each of the students had registered on a current caseload [say between six and eight]. That is, upwards of forty-eight individual clients were thus identified with a particular practitioner. It followed, therefore, that six students could have had working relationships with up to forty-eight different Keyworkers at any one time. Indeed, over the period of several months, this number could have been swollen by other Keyworkers who were no longer 'current', but were engaged by dint of being identified with clients who had been both recruited and discharged earlier in the time frame of the Branch. Because students were free to recruit their clientele at any treatment facility, wherever it was located, the practical issue for tutorial staff was not only the large numbers of staff involved, but also the physical distances between them all. The same practical issue impacted on the student experience of the

Branch model, where, as one practitioner reported, students were "chasing their tails and wasting their time":

> "You find that so much of your time is not actually engaged in clinical practice. That's the big worry, really. That so few hours out of the week are actually working with people and so much of it is driving around, killing an hours time here, making phone calls to arrange things for next week. I think a lot of people are trying quite hard over it [client allocation model]. Its just that there are difficulties with, you know, staff time basically is one of the big difficulties; practitioner time". [Student]

The lack of practitioner time to be able to help student learning was widely acknowledged. The extent of such difficulty inclined one practitioner to caricature the Mental Health Branch as "self taught, distance learning course", while another saw students as "rootless". By this was meant the degree to which students had comparatively little connection either with the tutorial staff or practitioners, either in amount or frequency, which fell well short of the innocent description of a "day-to-day" commitment reported in a ward document. Paradoxically, however, the tutorial staff acknowledged that the Branch "would collapse without the goodwill of Keyworkers". Evidence to this effect was observed in one clinical setting where the competing demands on time and energy had reached breaking point:

Practitioner "We really cannot cope with the level of work that is expected of us....we have come to the point where we are saying 'Look, we can't do this any more'. Because the next person that might come and ask me to pick up a client here could be one of those people who needs me a lot. I just haven't got the time and commitment for it, unless resources are forthcoming.

Tutor "I think that's fair comment because the Keyworker role is crucial to the scheme. Originally we thought the Supervisor was the

priority, but the reality of it on the ground is that the Keyworker is going to make or break this course. You are the people who have to make a judgement, put pen to paper, and say confidently 'Yes, [name] is trustworthy, reliable and is safe to carry out that practice'. Someone else, you're not sure, because you haven't seen them often enough".

Practitioner "I don't think its good enough, really. Its a big responsibility. All the students would need more than we're physically able to give....I am not happy. I feel sad that we have got to the point when [name] will be the last Branch student that we have. I just had to call a halt. I say that whoever comes in now on the Branch that wants to pick up clients here we must say 'No'. We just cannot do it".

Tutor "I am very sad about that...I think it has got to be thrashed out, because the conflict will arise when there is a contractual obligation on the Trusts to provide places for students. You can see the scenario. That may not be a bad thing, because managers will have to think carefully; if we want to train and we want students in there, we've got to provide the resources".

This fragment of dialogue, which took place during an ostensible tripartite supervision session with a P2K student, encapsulated many of the local features of this Centre affecting student learning; viz. the assumptions about available practitioner time; the pivotal role of the Keyworker; the relationship between Keyworker and Clinical Supervisor and both in relation to tutorial staff and students; the preparation of practitioners; the adequacy of the assessment strategy; the power relation between service and education; the matter of resources and the political commitment to devote them.

In a second clinical setting, the demands of being a Clinical

Supervisor [a role which involved a Branch-long commitment to oversee the students learning experience] had been examined by the permanent nursing staff. Here, too, work-overload was anticipated which, it was predicted, would detract noticeably from patient care. One practitioner described a strategy which was being widely adopted, on the Team Leaders advice, to delimit the number of P2K students it would be possible to supervise. It was simply to decline the Colleges' invitation to be identified as a prospective Clinical Supervisor.

In yet another tripartite supervision session, which involved different individuals in a quite different setting, the same themes recurred:

Tutor "Right, well its been a couple of months since we last met. I think today, really, just to check out the supervision role and how you think its going generally...."

Practitioner "First, to say that we haven't had a supervision session, for one or two reasons really. Mainly, because of communications between us two, really...."

Student "If I ever really needed to contact [name], I could have easily done so and re-arranged it [supervision appointment]. Personally, it hasn't really changed my view point. It just went wrong...."

Tutor "So from today onwards, what do you?..how do you?..like you say, if you have time slotted in when [name] can ring you up..then...."

Practitioner "Well, we need to make a time, don't we? when we can definitely say is yours..roughly once a month or something?..."

Student "Yes, about that".

Tutor "So, in general terms [name], you feel you're getting on with the job in terms of your working with the key workers, with [named supervisor] in the background to access as and when you need to....

Student "Well, yeah. The supervision part is fine with me, despite the little mistakes of the last few meetings, that's fine. But I'm having a bit of hassle really, much along the same lines as last term, with the keyworkers...For example I picked a client up and then went back the next week I went back and she was gone. And I didn't really know anything about it. Its hard to keep checks on it. The difficulties of time, because the Sisters they're quite busy, so its quite hard to actually get feedback, and supervision, and any sort of assessment".

The reason for the P2K student above to re-negotiate terms with a new Clinical Supervisor was because an earlier relationship with the role-holder had not worked. She was a Ward Sister as well as a Supervisor, which meant that she was "a sort of advocate for the student; abstract and separate from the assessment process, who couldn't free herself" when the student went onto the ward.

> "There would be huge silences for six weeks, we just didn't speak. I was thinking 'well she's a professional and this shouldn't happen'. I should have corrected it myself, I suppose, but I just let it dribble on and it finished amicably. Its just the clash of the two roles, I think. Now, my supervisors fine. I only see him once every month and chat about any difficulties I've had and he suggests things. I doesn't effect him that I am having difficulties, because it doesn't impinge on his territory". [Student]

Thus, students met infrequently with those who had been identified to help them with their learning in non-college settings. Moreover, Clinical Supervisors and Keyworkers met rarely, if at all; indeed, for the most part, the Clinical Supervisor did not know who the Keyworkers were. Keyworkers,

themselves, also met one another rarely, if at all, and would not necessarily know who each other were. Tutors very rarely met with either Clinical Supervisors, or Keyworkers, or the students, for reasons described earlier. In such circumstances, the notion of supernumerary status was widely regarded as redundant and student learning was "catch-as-catch-can....mainly just instinctive, more than anything; intuitive. Its hard to say where I learn, really. There's no real structure, apart from the College, now reduced to a day a fortnight; a little oasis in the wilderness, that I used to revel in and like".

Similarly, such disconnectedness posed a set of issues not only in terms of the adequacy of student support, but in the development of a cogent assessment strategy.

> "I've had lots and lots of problems, in most settings, about assessments; this point that they haven't actually seen me do it [practice]. Usually over some minor point, I feel. I seem to get embarrassed by their lack of knowledge or their bloody-mindedness....digging their heels in and making it awkward for people. They work in a profession where there's a lot of people that are quite powerless, [who experience] learned helplessness and all of these sort of things, and they seem to inflict it on the students". [Student]

As one practitioner put it, "we should all be working to the same agenda" as if to imply that this was not so. The fora for exploring just such, a two day in-house preparation, "was OK, but not terribly helpful". These events were reported not to have been well supported ["because staff can not spare time to attend"] while those that did so used the time to "moan about the changes in the NHS". A tutor confirmed that the programme of practitioner preparation "did not take on board the issues, as

it must, and was not subject to quality control, or evaluation".

> "Well, to be honest with you, I apply what I've learnt as a counsellor and as a therapist to patients, to the supervision of students. I could invest a lot more time in learning more about techniques of supervision. There was a Supervision course happening in London, it cost a lot of money and a lot of time, so...I would quite like something a bit more local, something just more intense, really. I find in-service training sometimes just to gloss through things; just to get people onto a list which says they're now Supervisors. I'd like something that takes its time to look at the real issues, to allow you to process the information and sit back and reflect on things. So [practitioners want] part of what has been put forward for Project 2000 [students]. Trained staff are not getting the same deal really". [Practitioner]

By far the biggest issues yet to be addressed regarding student learning, in whatever forum, laid outside the contemporary experience of all those involved with the educational enterprise. The political dimension threw into sharp relief the tension between the interests of service and education and fundamentally threatened the conceptual basis of the programme. By the last term of the Mental Health Branch, students must have disengaged from all the clients they had recruited onto their small caseload, in order to commit themselves to an "all modular scheme" for the final sixteen weeks of the course. Contracts had been agreed with the Trusts "to put bodies in various clinical placements; we must comply with that, otherwise we don't get the money. So, sixteen weeks rostered service in a named area". It had been reported that "more recently" pressure had been exerted to give twenty-five weeks "back to service".

> "Now, if they [Trusts] turn round and say they want all twenty-five weeks, the client allocation scheme as we know it would have to terminate. We couldn't run it, because it would only run for two terms. So, in a way we may be under

pressure eventually to go back to a traditional scheme.... rostered service screwing-up client allocation" [Tutor]

Given this eventuality, one tutor was inclined to "scrap the whole thing and have our own Masters course, so we have a complete package; not unlike the midwives, with direct entry into psychiatry".

Stage: 2
Branch: Mental Health
Case Study: Centre C

During July and October 1992, data presented here were derived from multiple sources in two field settings. This included two separate days of non-participant observation [NPO] in a psychiatric hospital, spread over two consecutive days and involved both a morning and an afternoon shift. Access to allow direct observation of the contribution that community psychiatric nurses made to student learning, much delayed while student allocation arrangements were negotiated between the College and field workers, was eventually denied.

Other data were derived from post-hoc accounts of actual experience, provided by three first level nurses practitioners who were responsible for helping a Project 2000 student to learn in two practice placement areas [hospital and community]; derived from the two students of nursing who were engaged in such experience, and from two Tutors who had link responsibilities for both areas. Data were also drawn from documentary sources provided by the respondents.

The setting in which hospital-based data were derived was a comparatively new twenty five bedded acute psychiatric admission unit of an established psychiatric hospital, in an "extremely poor" large Inner City area, "with numerous trans-cultural problems", close to the College. The criteria for admission to the unit, for people of both sexes, was "particularly high" and

this was written into the admission policy. It was argued that because of this, it was "extraordinarily hard" to work there because "everybody comes here is significantly iller than anywhere else and that's the attraction of working here, believe it or not". The unit staff engaged in "a lot of follow-up and liaison with the community, probably more than most". That, it was asserted, made it "a unique place to work; it's quite successful, but it's very hard work". The Unit was said to be understaffed by seven nurses [who were about to be recruited "very smartly"], though could still call upon "about eight RMNs, plus three Senior Nursing staff". In addition, the Unit accommodated a number of Agency RMNs, three Consultant Psychiatrists, two combined degree students and two Project 2000 students. The Unit had staff identified to organise formal, in-house, educational sessions to which all students were invited. Moreover, P2K students had access to "anything; there's lots of things going on here, lots of different seminars and teaching". A system of Primary Nursing was in place.

The community setting was located some eight miles out from the main College campus, though still within an urban context, in a domestic dwelling converted into a Community Mental Health Centre. The accommodation provided a base to six CPNs, with connection to a further two based in General Practitioner surgeries, and other nursing staff whose clinical work was from within the community Centre. Students were allocated to placement areas in a conventional 'block' manner.

The placement of Project 2000 students into community settings was a "big issue" at this Centre. It was explained that the local mental health nurse training emphasised community experience, which amounted to two terms in the programme ["two-fifths of our placement"]. However, an "unspoken agreement" to place students with the community psychiatric nursing service from a nearby hospital had been recently "blocked; so we didn't have anything there". The implication of this alteration to existing arrangements meant that all community placements had to be found in the CPN Service of a neighbouring Health Authority [HA]. This had met with an indignation which "sparked off a resentment" that the CPNs in the said hospital "were not pulling their weight", especially when it was known that "there were community psychiatric nurses in [hospital name] who did not have any students".

It became necessary for the College to negotiate a separate agreement [unwritten] with the person who was in charge of the CPNs [since changed] in a neighbouring HA, to accept twelve Project 2000 students from the Mental Health Branch Programme. "We only had eight students, as it turned out", so a problem was not envisaged; "eight students and twelve placements, fine". However, students from courses other than the P2K course ["Enrolled Nurses, RGN to RMN"] managed to get first call on the twelve places, without the knowledge of the negotiating tutor; "when it came for our students [P2K] to be placed, they just didn't have the places". A logistical awkwardness thus arose,

which was hastily remedied by using "personal contacts, literally five days before the students were due to arrive; totally unacceptable, you can't prepare the placement properly".

Such an account was illustrative of the general issue concerned with identifying appropriate practical placement settings to second students of nursing on Project 2000 courses, given their increasing community orientation, within the fast-shifting political environment of mental health service provision. Moreover, the account provided the backdrop against which access to the direct observation of CPN practice was denied.

It also provided, however, an opportunity to explore the impact that such organisational difficulties had on the learning experience of the individuals involved and how they were handled by the qualified nursing staff, who occupied formal roles to help students learn in practice.

> "For the first week, I was very miserable because there wasn't anything going on and I was sitting in the staff room. I saw [link tutor name] and he said 'How's it going?' and I said 'I'm not very happy, I don't actually like it at the moment'. But that was all I said; because I thought 'I've only given it three days, I can't really make a judgement'. Then we had Group Dynamics that Thursday [in College] and I was saying how upset I was and felt that I had been pushed aside, you know, dumped here [placement] because there was nowhere else. That got back to [link tutor name]....then on the following Monday [link tutor name] was waiting here and he sort of frog-marched me into this meeting with [supervisor name] and sat me down and said 'would you like to tell [supervisor name] everything you have been saying about this place'. I said 'I haven't really said anything'. I said 'what I said was in Group Dynamics, which is a closed group, and confidential'. He said 'would you go ahead and tell him'. I was devastated. I sat there in tears". [Student]

The student felt "it was my fault"; an impression she had not been disabused of since. During the three weeks which had followed the incident, the link tutor "had not visited once to see how I am getting on, or what the placements was like; not at all".

> "I know it sounds awful, but I'm glad that [student name] is having a bad experience as well. I'm glad its not just me, because I'm sure I'd feel even worse if it was just me." [Student]

Ironically, the students supervisor thought that her relationship with the link tutor should be regarded as more important than the relationship she had with the student "because we hardly get to know one another, so I am never really sure what a student actually expects from me and expects from the supervision". Moreover, as if to push the scenario into farce, a separate tutor [with responsibilities to coordinate the cohort of students experience] confirmed that the link lecturer system "is supposed to pick up if supervisors aren't feeling confident, or if there are problems. Whether or not that's happening, I don't know".

But elsewhere a different interpretation of the link lecturer role was articulated, in which trouble-shooting was not part of the brief. Here, instead, "quite a big role" was seen for link lecturers to role model supervision, or model aspects of it. However, this activity was "probably not" noticed by practitioners with supervisory responsibilities for student learning and it was thought "really difficult to work out the best way of doing it [helping supervisors]". This tutor was not

"terribly convinced by the whole process of bringing people [practitioners] into College for a study day".

Never the less, the conventional wisdom in this Centre was just such. It was recognised, however, that Practice Supervisor study days occurred infrequently; on alternate sites, upwards of fifteen miles apart, so it was difficult for staff to travel such distances; the courses got very full and staff experienced a difficulty to find sufficient time to be released from direct patient care.

These impediments not only militated against practitioners being exposed to notions of supervision, but also an acquaintance with the new assessment processes which were particular to Project 2000 Branch programmes. An uncertainty about the level at which the assessment judgements were expected to be made permeated through both the practitioners and the students themselves. One felt that "any qualified member of staff should be able to do it". However, such a view was inappropriately held:

> "I think I am probably going to have to play it by ear [assessment of practice]....I guess I'm not really sure. Most of the time I think I am probably going to have to give her [student] the benefit of the doubt....I am aware there are differences [between RMN training and P2K], I am not so sure that I understand them....I would look to the link tutor [for an explanation of the differences]. I think I sound very negative. Cynical as well".
>
> [Practitioner]

Here, too, an optimism was misplaced because tutorial staff played "very little part in assessment" and "relied on the supervisors, part of whose role assessment was". Indeed, felt

uncertain about the issue themselves:

> "Well, ahh, now that's a good one, isn't it? Are we assessing practice at Diploma level? Has anyone else got any idea what Diploma level nursing practice actually is? I have a big problem. I don't think anyone has got an idea Diploma level nursing practice is. I don't know that we're even saying we're training people to a Diploma level. I think we're educating people to a Diploma level, in an academic sense, and that we're training them as mental health nurses to the level of Registration....but it has not been addressed, to my knowledge. I haven't addressed it in a formal way. I've addressed it in a moaning over a cup of coffee way. [Practitioners] are assessing clinical practice according to their own standards, what they consider to be what a psychiatric nurse should be able to do, using new-fangled documentation". [Tutor]

The level at which the assessment of practice should be made was inconsequential for one student who did not have any practice to assess:

> "I've got a meeting with [supervisor name] this afternoon to do my Bondy [assessment], but I don't know what we're going to do it on. I really don't. Obviously. I've sat in with clients and watched [supervisor name] through the mirror and said how I felt about watching it, what I thought, given my opinion and all that sort of thing. But I don't see how things like 'acting non-judgmentally with clients'....but they can't actually observe me with a client to see whether I am non-judgemental, or not. [Student]

Such a position was regarded as indicative of this supervisors interpretation of the students supernumerary status as "purely observational and not actually taking part in anything". Elsewhere, in yet a different placement setting, P2K students experienced an antithetical understanding of supernumerary status. Here, where the qualified nursing staff themselves had supernumerary days, students were actively encouraged to deliver patient care under close supervision. Students were observed to be placed in positions of very considerable responsibility and were happy to be so, in the confident knowledge that all team

members [including and especially the formally identified supervisor] were available for immediate advice and support. An example of such was a Project 2000 student who had accepted the Shift Manager role from 7am till 3pm. This involved [almost literally] occupying the driving seat in the central observation room to orchestrate the work activity of all members of staff [including that of the Nurse in Charge and Staff Nurses], on a minute-by-minute basis, to ensure maximum quality care to all inpatients. A metaphorical baton of the 'responsible supervisor' for the student, was passed between qualified staff members as they engaged business on and off the Unit, so that continuity of cover was ensured. A similar arrangement was used in the nurses clinical practice, for the safe supervision of at-risk patients. An effortless system of checks and balances meant that the student was always challenged and never unsupported. Such was the level of confidence and team cohesiveness among team members, that despite the bedlam surroundings of the Unit, a lightheartedness never-the-less prevailed:

Supervisor "Nicely stressed now?"
Student "Yes"
Supervisor "Its good to get up to a good functional level of stress"
Student "Yeah"

Later, the same student had lead responsibility in a ward round under the constant watchful eye of her supervisor, and later still led the handover to oncoming qualified nursing staff, students and others. Because she was wholly engaged in meaningful activity, she regarded the Unit as a "great learning environment" and thought her supervisor to be a "good teacher".

This, in sharp contrast to her first Branch placement where she "could have cheerfully throttled the woman" who was identified to help her with her learning, because she was "not provided with an opportunity to put theory into practice". Such positive feedback was welcomed by the Team Leader who was clear about the reasons why students held such a view:

> "I think we [team] transmit the ambience and philosophy of our ward with consummate ease, enthusiasm and commitment and I think its that which infects them [students], which is why we are successful. And that is supported by formal academic input. I think that is what we do best and I think that is why the students like it here. It is really important, no matter what anybody says, students aren't going to learn unless they like it somewhere". [Practitioner]

Such a tenet was given empirical credence when it was looped back to earlier accounts from unhappy students where learning had been made difficult. However, such a tenet was independent of the structure and value base of the prevailing educational paradigm, currently Project 2000. Indeed, it was the case that the senior nurse who was instrumental in developing and maintaining the welcome regime in the Unit above, wanted a change to the present arrangements:

> "We could have [a programme of] three months on the ward, then a two week block period, then three months on the ward, over a period of three and a quarter years, with a finals at the end of it. That was a good system". [Practitioner]

A similar sentiment was remarked upon by a member of the tutorial staff who coordinated the timetable for one cohort of P2K Mental Health Branch students:

> "I wouldn't have done it. No way. I would never have done a course like this. Complete waste of my time." [Tutor]

Summary of key points derived from Case Studies [Stage 2]

The following list of issues were raised and explored during interviews with students, practitioners and tutors; during direct observation of their practices and from documentary evidence, in the course of six Case Studies.

Adult Branch

-Practitioners who were identified to help meet students learning needs, valued students who were enthusiastic and eager to learn.

-Students valued practitioners who were motivated to help them learn

-On occasion, students felt their supernumerary status excluded them from being part of the nursing team.

-Practitioners did not enjoy the benefit of supernumerary status and had to balance the burden of their responsibility to service delivery with their commitment to P2K students, with some difficulty.

-Tutors had additional demands made on their time as a result of the introduction of Project 2000, which had reduced their visibility in practical placement areas to students and practitioners.

-The assessment of student practice was undertaken with various levels of expertise and rigour.

-There was a confusion amongst practitioners about the level of practice at which students were assessed in each setting.

-Practitioners used a range of teaching strategies to help students learn; strategies which were student-focused and patient-centred were particularly valued.

-The relationship between student and practitioner influenced the learning experience.

-The tutors role in problem-solving was acknowledged in all settings.

-Despite their perceived lack of preparation, practitioners were able to assist students link theory to practice, on occasion.

-Students felt that they could discriminate between good and bad practice and identify practitioners to use as role models.

-A distinction between 'link' and 'personal' tutorial responsibilities was not always apparent.

-An uncertainty existed between students and tutors about what the latter's role was, in relation to that of the practitioners in practical placement areas.

-Differences were apparent in the students role in the provision of care, between hospital and community settings. Greater expectations were conspicuous in hospitals, than outside them, where a caution in allowing students to engage in care-giving was exercised by practitioners.

-Learning opportunities for students were lost as a result of competing demands on practitioners finite time.

-Although students valued patient-centred teaching, formal teaching sessions were more commonly based around tasks or medical conditions.

-A real concern existed, particularly amongst practitioners, about the abilities of Project 2000 students upon qualification.

-Students placed in settings where patient care was organised around a system of primary nursing, appeared to have a more positive learning experience.

Mental Health Branch

-Project 2000 student learning was compromised on a 23-bedded acute psychiatric admission ward, which was staffed by one 'D' graded staff nurse [who had been qualified 7 months], supported by two young Nursing Assistants, two P2K Branch students and one RMN student. Under such conditions, high quality nursing was not possible and students were exposed to poor [but reality based] role models.

-An organisational arrangement which required students to spend 60% of their time in hospital and 40% in the community, per placement, was not favoured.

-Town based students who were dependent on public transport to travel to remote rural areas, experienced logistical difficulties and reduced learning opportunities.

-When staffing numbers were modest, students felt obliged not to leave a placement to engage matters which were educationally led, but regretted that the practitioners were unable to provide the necessary support to them if they remained.

-It was not unusual for Project 2000 students to be regarded by practitioners as burdensome.

-One to one debriefing, through reflection upon actual clinical experiences, was universally welcomed by students [when it happened] independent of context.

-A client allocation model of a Mental Health Branch Programme, which had been selected in favour of a conventional placement allocation model, was found difficult to operationalise in practice and student/client contact time was compromised.

-The demands of Provider Units on Project 2000 students rostered service, threatened the conceptual basis of a client allocation model of learning.

-The location of appropriate practical placement settings in the community was an increasingly general concern.

-Practitioners experienced a difficulty to find sufficient time to be released from direct patient care, to attend study days which were designed to help them meet the learning needs of P2K students.

-In a setting where qualified nursing staff had supernumerary days, students were actively encouraged to deliver patient care under their close supervision. Such was the confidence and cohesiveness of the nursing team in this setting, that an effortless system of checks and balances meant that Project 2000 students were always challenged and never unsupported.

-A good learning environment was regarded as one where qualified nurses transmited an enthusiastic commitment to student learning and where students were wholly occupied in meaningful activity.

The issues summarised here, which were all embedded in data captured in Stage 2 of the study, illuminate the pre-specified research interest of the English National Board and address each of the study Aims. As in Stage 1, it can be seen that most of the issues were common to both Branches. Not only were most of the issues found not to be discernably different by Branch, but since a discrete cultural context for each Centre or Setting was not apparent, most of the issues were also applicable to all. In the following section of this document the findings from Stage 1 and

Stage 2 of the study will be discussed in relation to literature published in the substantive area.

DISCUSSION

To address the policy issues identified by the English National Board, this research adopted a methodology which obtained data from the main actors involved with the practice-based educational experience of students in the Adult and Mental Health Branches in three Project 2000 course centres in England. The student repondents were drawn from the first two P2K cohorts in the three Colleges, each of which was designated a Project 2000 Demonstration Centre.

The findings from analyses within cases have been reported and each have a free standing integrity. Subsequent cross case analyses revealed a set of issues which were mostly common to both the Mental Health Branch and the Adult Branch in the three Project 2000 course centres. These are discussed immediately below and followed by those unique to Mental Health.

It was widely reported that the helping roles adopted by practitioners and tutorial staff [however they were entitled locally] were often understood in different ways, were not systematically assigned, were enacted differently and were relegated according to competing demands. Thus the inter-relationships between the different roles for the provision of teaching, support, supervision and role modelling, were bereft of clear patterns of association which could be distinguished. Such findings concurred with those reported by Hagerty [1986], Sloan and Slevin [1991] and Wainwright [1992].

Practitioners

Practitioners were uncertain about the functions they were expected to perform in most of the helping roles they occupied. The nature and variability of these roles was evidenced in the wide range of functions which were identified: these included being available, arranging programmes, providing information, facilitating learning, planning objectives, listening, counselling, supporting, offering direction, role-modelling and assessing. Here too, none of these functions were uniquely identified with particular roles.

Most practitioners wished for greater clarification of their different roles, a greater familiarity with the P2K curriculum and a development of their assessment skills. The lack of educational preparation for practitioners was apparent in the methods adopted to facilitate learning in practice settings, which [particularly in the Adult Branch] were frequently task-orientated and not patient-centred, nor relevant to student learning objectives. In such circumstances, together with a lack of coordinated contact between practitioners and tutors, the task of making connections between theory and practice was formidable.

Supernumerary status

The notion of supernumerary status held a range of understandings, which students and practitioners interpreted in several different ways. Apparent differences between the actual experience of being supernumerary and the experience of being

rostered were contentious. Students supernumerary status was not always wholly embraced by practitioners, especially when staffing levels were low and, on occasion, reported as dangerous.

In such circumstances, students felt obliged to stay in a practice setting when staffing levels were low, but also felt resentful at not having the necessary support from practitioners when they remained. Supernumerary status meant that students could not be counted on to provide a predictable contribution to service provision; the corollary was that staff could not be counted on to provide predictable educational support to students. Project 2000 students, therefore, were sometimes regarded as burdensome in practice areas where the level of staffing was thin. Moreover, under such fraught staffing conditions, poor quality nursing practice was unavoidable, and was observed by Project 2000 students. Learning opportunities were reduced and occasionally lost. Low staffing levels not only further disadvantaged students with skill deficiencies, but put at risk high quality patient care. Teaching sessions, planned for the benefit of Project 2000 students, were also forfeit when staffing levels were critical. This, because patients always came first; an understandable reality, although one with unsatisfactory outcomes for all concerned with student learning in practice areas.

Placements

Students in both Branches complained of short placement periods

which, when combined with staff sickness and holidays, meant that student/practitioner contact was often infrequent and superficial. With limited opportunity to practice and a lack of relevant and timely theoretical insights upon which to reflect and to test in vivo, students expressed an apprehension about their comparatively low level of skill development; they did not know whether responsibility for this lay with themselves, with practitioners or with tutors.

Assessments

Across both Branches, it was recognised that assessment of students' practice was problematic and the instruments for so doing were ambiguous and open to considerable subjective variation. Indeed, practice was often judged independent of a practitioner having witnessed it, but rather on an articulation by the student of unobserved practice, or through discussion with others.

These empirical findings, derived from the present study, were comparatively novel in terms of Project 2000, but were neither original, nor unique to the new educational preparation; the work of While [1991], for example, recently reported similar findings, the like of which have been in the public domain for nearly two decades [Long 1976]. However, such observations were less noticeable in community settings, or where a system of primary nursing was in operation and the division of labour between staff was explicit.

Role of Tutors

In the present study, the general finding was that tutorial staff played an insignificant role in the assessment of practice. However, all tutorial staff had link responsibilities for specified practice areas, including generalised notions of trouble-shooting [to provide a welcomed safety net to students and practitioners], of liaising, maintaining lines of communication, giving support, listening, dealing with problems, monitoring progress, keeping staff up-dated, negotiating placement allocations, looking at assessment of practice documents, clarifying the roles of practitioners, helping to achieve objectives and mentoring the mentors. Scarcely any clinical teaching by tutorial staff was either reported, or observed, in practice areas.

Nor was any intentional role-modelling reported; absence of which was regarded as especially troublesome as a discrete activity in mental health settings, even if it were either possible and/or desirable, and particularly so when tutors were rarely seen. Such a position has also been recently reported by Bodley [1991]. The notion of 'intent' in role modelling, was to distinguish it as an activity which was separate from a simplistic notion 'working in front of the students'. For, given this interpretation, all qualified nurses role-modelled by dint of being on duty; but this invariably lacked sentience. In this, there were echoes of the traditional role for practitioners in relation to a passive form of teaching reported by Donovan [1990].

Tutorial staff were often overwhelmed by multiple, and sometimes competing, demands on their time and energy; for example, to plan new programmes of education, to accommodate unfamiliar material, to teach at a different educational level and to employ new teaching methods. Very similar findings have also been reported recently, in other educational centres, by Payne, Jowett and Walton [1991]. Some tutors reported not having taught at DipHE level before and, on occasion [like practitioners], not having been prepared themselves at that educational level. It was not rare to find, therefore, that these competing interests were in addition to the demands of their own educational preparation to a higher level.

With little opportunity to visit practice areas, and with Project 2000 students yet to consolidate a confident position, tutors struggled to establish a new identity and an appropriate role within the context of the new course arrangements. Most held an ombudsman role, referred to earlier, which was often focused around the general misunderstandings of the Bondy assessment booklet [see Bondy 1984] and student learning objectives. Tripartite meetings held in practice areas between students, practitioners and tutors, were as welcome as they were rare. Incidents were reported in which seminars and teaching events, organised by practitioners, no longer included representatives of the tutorial staff, because they had fallen out of the consciousness of field staff. For many tutors, the actual difference between 'personal' and 'link' responsibilities was

sometimes difficult to account.

Diploma-level practice

Learning objectives were not always regarded as realistic, given limited time for students in the placement areas, together with suspect inter-rater reliability, imprecise wording in the documents and widespread uncertainty about the required educational level. Overall, the notion of Diploma level practice was very poorly understood. Despite recent confirmation from the English National Board [1992] about how 'important it was to realise that a DipHE was not just more of the same as the existing first level courses, but required a fresh approach consonant with a higher education award', this had yet to penetrate the working reality of most of those on the ground, either in the Colleges or in the field.

Uncertainty and frank, unselfconscious, ignorance was reported by practitioners about the educational level at which the assessment of Project 2000 students practice should be undertaken. Although the English National Board course number 998 [Teaching and Assessing in Clinical Areas] was often thought of as the most appropriate course by practitioners who had not completed it, those that had were not unanimous in their reports of its usefulness to Project 2000 students, not least because of the apparent variation of orientation and quality between different ENB998 course centres. A more appropriate preparation was poorly articulated by practitioners, because it was often the

case that they did not know, what they did not know, would be useful to them in working with P2K students. A longer working experience of such was thought to be necessary, in order to identify areas for specific educational attention.

Tutors reported that, although practitioners were the appropriate personnel to occupy these helping roles in practical placement areas, not all commanded the knowledge base necessary for work with Project 2000 students. They regarded the apparent lack of preparation of practitioners to work with P2K students in much the same way as they regarded their own; uncertain.

Differences between Branches

In addition to these issues, which were common to both Branches, cross case analyses also revealed matters of difference and emphasis between them. Such distinctions betrayed an experience of mental health nursing education, through the Project 2000 courses in the present study, as having been subtley different from that of adult nursing. For example and almost without exception, Mental Health Branch students criticised the content of the Common Foundation Programmes [CFP] for being biased toward 'general' nursing, to an extent not reported by their Adult Branch student colleagues. In this respect, their experience could be understood in terms of the perceived differences between conventional educational preparations and Project 2000 courses; that is, the Adult Branch was seen [in a relative sense] as a seamless continuation of the CFP, whereas the Mental Health

Branch was largely irrelevant to a course which, for many, only felt as though it began a year and a half after it had actually started. Here were echoes of empirical research by Clarke [1991], which prompted expressions of concern about whether potential 'psychological' students would be 'capable or willing to undergo a broad based foundation course'. In the present study, differences for Mental Health Branch students between the CFP and the Branch, and differences between general and psychiatric parts of the course, were sometimes considered as one and the same.

On placements, Mental Health Branch students more often worked alone and unsupervised for much of their time, which [in terms of a methodological retrospective] meant that long periods of non-participant observation to identify 'head-to-head' learning encounters with qualified nursing staff, was rare. This, despite a wide range of mental health practitioners who had been identified to help them learn in non-college, practice areas and who occupied several role titles. As a corollary, a plethora of role functions were described in ways which were not mutually exclusive to each role title, including facilitating, monitoring, supervising, supporting, guiding, role modelling and assessing. Some practitioners compounded this semantic confusion, by being unaware of the role title they occupied in relation to student learning. Such findings accorded closely with those which were derived from a review of the American literature [Hagerty 1986] and from a recent Scottish survey [Boyes 1989].

Here, too, almost without exception, mental health practitioners were concerned about the adequacy of their own preparation to work with Project 2000 students. Some practitioners did not know what they did not know. This was particularly so in relation to the assessment of student practice, where it was not uncommon for students to play the game of identifying practitioners who were regarded a 'soft touch' for the purpose of assessment of practice. This activity usually involved practitioners in second marking the scores which students had given themselves of their own performance in practice areas.

Tutors, particularly those identified with the Mental Health Branch [though not exclusively so], confirmed that they played a modest, indirect role in the assessment of students practice and felt themselves to be at subsequent risk of assessment de-skill. Again almost without exception, tutors wished for more of their time to be spent in practice areas and, in general terms, regarded the arrangements for student contact in practice areas as unsatisfactory. Similar findings have recently been reported by Crotty [1993] from her Delphi study of 201 nurse teachers in 25 Colleges of Nursing and Midwifery. Available tutorial time, modest as it was, did not always coincide with students' availability in practice settings; tutors lamented the experience for students in these areas for its brevity and lack of continuity. In particular, sharing practice time between hospital and community mental health settings within a single practical 'placement' period, was often reported as an unsatisfactory

student learning experience.

Tutors reported structural impediments to satisfactory student learning, including a theoretical input which sometimes followed a practical experience and which, on occasion, militated against an easy linkage between theory and practice. Similarly, given the geographically dispersed nature of contemporary mental health care services, long distance travel, by students dependent on public transport to reach client settings, also militated against full advantage being taken of the educational experience. Many practitioners described a personal pressure which arose from the volume of students for whom they were responsible; too many students and not enough placements. Demands on practitioner commitment were observed which, on occasion, had reached breaking point and future student contact had been declined. Arrangements had already been planned by practitioners which would de-limit the number of qualified staff who could be identified to act as formal helpers in student learning.

A curriculum model for mental health nursing, which had abandoned a conventional placement allocation in favour of a client allocation arrangement, was reported and observed as logistically difficult to administer. Under such an arrangement, the need for tutorial staff to relate to a very large number of practitioners led to an extremely low tutorial presence in non-college settings. Similarly, more student time was spent alone and not engaged in clinical practice, than in conventional curricula

arrangements, even where the level of student engagement was already low. Here, as elsewhere, service providers had substantially influenced the local interpretation of rostered service, which students provided during their course. This threw into sharp relief the tension between the interests of service and education and, in the present example, threatened the conceptual integrity of the client allocation curriculum.

Everywhere, the students looked to the practitioners for help; the practitioners looked to the tutors for help and the tutors looked for someone themselves.

Models of good practice

Models of good practice for student teaching, support, supervision and role modelling were found [although rare, in empirical experience of the present study] and the commitment of qualified nursing staff to Project 2000 student learning in such locations was considerable, given the parameters imposed by the finite resources available. Such commitment was especially the case where qualified nursing staff had the benefit themselves of supernumerary days, and so had sufficient disposable time to concentrate on educational matters. Where this was so, a noteworthy dedication to the learning experience of mental health nursing students was observed.

In both Branches, despite such uncertainties, students were observed to thrive on being given practical responsibility, in

real time, while under close and continuous supervision.

Debriefing, in particular, through reflection upon actual clinical experiences, was universally welcomed by students, independent of context. Moreover, all students who worked in close collaboration with well motivated, articulate, fully informed, enthusiastic qualified staff, reported that they benefitted hugely from so doing. Similarly, practitioners were often triggered into a positive mode, by the Project 2000 students themselves, who either initiated or reciprocated an enthusiasm to learn. This had always been the case in both Branches, practitioners reported, even under previous educational arrangements.

CONCLUSIONS

On the basis of empirical research reported here, some confusion and misunderstanding of roles between Project 2000 students, practitioners and tutors has been revealed. The relevant information about the new course was not available to all the people who needed to know. As a consequence, a mis-match of expectation between different role holders was common. The tutors felt that, generally, practitioners did not have the necessary knowledge and/or skills in some important areas, to help students make connections between theory and practice. Similarly, practitioners were less than convinced by the level of clinical credibility of their tutorial colleagues. These deficiencies were widely acknowledged and, in the case of tutorial staff, were attributable to their low visibility in clinical areas. Tutors no longer saw themselves as part of the clinical team and the relationships between them and practitioners, therefore, were often weak.

As a result of low clinical involvement for tutors, students had little or no contact with their link tutors in non-college settings. This was often compounded for students by the widespread difficulty of not being able to meet with practitioner staff for regular, frequent and meaningful sessions. These sessions sometimes approximated a notion of supervision of practice, quite independent of whether the practitioner concerned was known as a 'Supervisor'. Indeed, findings reported here, derived from in-depth interview and observational data, and

supported by survey results, showed that role titles and role functions were entirely interchangeable and, on occasion, disregarded as irrelevant. None of the functions were uniquely identified with any of the reported role titles. That is; Assessors did more than assess, some supervised. Supervisors did more than supervise, some assessed, others mentored. Mentors not only mentored, but some supervised, yet others assessed.

Part of an explanation for the unpreparedness of practitioners and tutorial staff to accommodate P2K students, was widely thought to have been the short timescale for the implementation of Project 2000. This was universally regarded as unrealistically tight. It largely fell to the students, therefore, to prepare the staff in the practice areas, rather than vice versa. However, a review of the courses within centres, should enable aspects of the situation which were problematic to be included.

A widespread uncertainty about the obligations practitioners and tutors had in relation to the educational level of the assessment of students' practice, gave rise to concerns about, not only the extent to which practical skills had been acquired, but also to their standard.

The role that supernumerary status had in the process of student learning was unclear and a consensus regarding an appropriate interpretation of its meaning was not apparent. Such confusion was shared by students, practitioners and tutors alike, and it

was not uncommon for students to sacrifice their supernumerary status in order to engage in nursing work. This was particularly so when staffing levels were very low, and/or when students were frustrated with a hands-off interpretation of the term.

However, in practice settings where supernumerary status had been successfully negotiated, students appeared to experience a more positive learning experience; especially where qualified nursing staff had days on which they were supernumerary themselves. Although this was an exceptional arrangement, it was indicative of a culture which was comitted to an enthusiastic accommodation of student nurses and their learning needs. Indeed, in more general terms, a positive relationship between students and the practitioners identified to help them learn in practice settings, was an important factor in student learning.

The present research was undertaken at three Demonstration course centres in England, during the introductory phase of Project 2000 and has drawn on the experience of those connected with students from the first two cohorts in each. Thus, the findings derived from this study, represented the early stages in the implemementation and may have accounted for some of the apparent problems.

Accounts have been reported here from key actors in these developments, which have reflected the different positions they adopted to explain the undoubtedly difficult issues involved with

student learning in practice. Put succinctly, there were those who regarded the issues as a temporary consequence of the newness of Project 2000, as well as those who regarded the issues as an enduring consequence of an extremely complicated and challenging aspect of the educational reforms.

RECOMMENDATIONS

From the conclusions based upon a discussion of the findings of this descriptive research study, the following recommendations are justified:

1. Given the widespread confusion, it is recommended that the range of role titles for practitioners and tutors should be rationalised and, following guidance to discriminate the functions attributable to each, the adoption of standardised terminology to ensure a national uniformity should be required.

2. Given the apparent inadequacy of present arrangements, it is recommended that a nationally recognised course should be developed, to replace the ENB 997/998 course, in order to specifically prepare qualified practitioners for their role in Project 2000 student learning in practice, which would include the practical techniques of debriefing and reflection and the assessment of practice at DipHE level.

3. Given the equivocal experience of students, a review should be undertaken of the structure and content of Project 2000 curricula. In particular, the length and content of the Common Foundation Programme, together with the length of time students spend in placements, should be critically examined for educational integrity and relevance.

4. Given the limited comprehension by students, practitioners and tutors, Diploma level practice should be operationalised and, thereafter, guidance should be issued to curriculum planners for this to be explicitly acknowledged in Project 2000 course [re]validation documents.

5. Given the variability within and between course Centres and Settings, the assessment of student practice should be thoroughly examined to ensure the reliability and validity of procedures in current usage and to identify the responsibilities of practitioners and tutors in the assessment process.

6. Given the deleterious effect on student learning of low staffing levels, a rigorous review of the adequacy of staffing in practice learning environments should be undertaken. Minimum numbers of appropriately prepared qualified nursing staff should be made explicit for each student placement, as a prerequisite to Project 2000 course [re]validation.

7. Given the vague understandings of the term, student supernumerary status should be further operationalised and, thereafter, greater guidance should be made available about the interpretation and use of this strategy.

8. Given the new demands on students, at Project 2000 course [re]validation events Panel members should be satisfied that arrangements will be in place to ensure that students will be educationally equipped to enable them to learn through practice.

9. Given the confusion over the division of labour between tutors and practitioners, in relation to P2K student learning in practical placements areas, a comprehensive review of the working practices of relevant staff should be undertaken and, in particular, a reconsideration of the use of tutor's time in practice settings.

10. Given the reported benefits, the means should be explored by which opportunities can be created for qualified nursing staff to have planned periods of supernumerary time, to devote to the educational experience of Project 2000 students.

11. Given the need for a sound cooperative effort between various staff groups, at Project 2000 course [re]validation events, Panel members should be satisfied that mechanisms have been developed to establish clear lines of communication between tutorial and service staff in relation to all aspects of the course, especially the learning experience of students in practice settings.

12. Given the potentially stressful nature of the undertaking, Panel members at Project 2000 course [re]validation events should be satisfied that the pressure on qualified nursing staff, arising from their dual role as a service provider and as a practitioner responsible for Project 2000 student learning in practice settings, has been acknowledged and not under-estimated.

13. Research should be commissioned to explore the development and evaluation of new roles, in selected sites, to assist students to make the link between theory and practice; viz, joint education/service appointments, lecturer/practitioners.

14. Given some indication that student learning experience was better served within the context of a primary nursing arrangement, dedicated research should be commissioned to investigate the actual relationship between primary nursing and the quality of student learning.

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Tables to show the findings derived from a survey of Principals of Colleges [N=42], who had lodged Project 2000 course documentation with the English National Board for Approval. Each was invited to identify the role titles adopted locally for Tutors and Practitioners who had responsibility for P2K students in practice areas. Moreover, Principals were invited to identify the functions which comprised each role.

PRACTITIONERS [Adult Branch]

	ROLES			
	Supervisor	**Mentor**	**Assessor**	**Other***
Number of Colleges using each title [n=31]	[17]	[15]	[12]	[9]
FUNCTIONS				
[No. of Colleges reporting each function]				
Assesses [31]	10	5	12	4
Facilitates [23]	9	9	2	3
Teaches [19]	5	7	3	4
Supervises [17]	6	3	3	5
Role models [16]	6	6	2	2
Supports [16]	4	8	1	3
Guides [13]	3	5	2	3
Counsels [9]	3	3	1	2
Advises [9]	2	4	0	3
Mentors [6]	3	0	0	3
Monitors [5]	2	0	1	2
Keyworks [4]	2	1	0	1
Other** [17]	8	5	1	3
Totals [185]	63	56	28	38

* includes 6 role titles [5 reported once only; 1 (Facilitator) x 4]
** includes unspecified functions, or reported 3 times and less.

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PRACTITIONERS [Mental Health Branch]

	ROLES			
	Supervisor	Mentor	Assessor	Other*
Number of Colleges using each title [n=30]	[20]	[12]	[12]	[13]
FUNCTIONS				
[No. of Colleges reporting each function]				
Assesses [30]	11	3	12	4
Facilitates [26]	11	9	0	6
Role models [20]	8	4	2	6
Teaches [19]	6	5	3	5
Supervises [18]	9	3	2	4
Supports [14]	3	7	1	3
Guides [13]	3	4	2	4
Counsels [9]	3	3	1	2
Advises [7]	2	3	0	2
Monitors [7]	3	0	1	3
Mentors [6]	3	0	0	3
Keyworks [5]	3	0	0	2
Other** [12]	3	4	0	5
Totals [186]	68	45	24	49

* includes 10 role titles [none reported more than twice]
** includes 6 functions reported 3 times and less.

TUTORS [Mental Health Branch]

	ROLES		
	Teacher:Tutor:Lecturer		
	Link	Personal	Other*
Number of Colleges using each title [n=29]	[19]	[21]	[5]
FUNCTIONS			
[No. of Colleges reporting each function]			
Facilitates [21]	9	10	2
Supports [18]	9	6	3
Teaches [14]	4	8	2
Counsels [11]	2	9	0
Advises [11]	5	6	0
Liaises [10]	9	0	1
Monitors [8]	2	6	0
Supervises [8]	3	3	2
Guides [6]	0	5	1
Other** [19]	5	12	2
Totals [126]	48	65	13

* includes 4 role titles [3 reported once only; 1 (Lecturer/Practitioner) reported x 2]
** includes 10 functions reported 3 times and less.

TUTORS [Adult Branch]

	ROLES		
	Teacher:Tutor:Lecturer		
	Link	Personal	Other*
Number of Colleges using each title [n=30]	[17]	[21]	[6]
FUNCTIONS			
[No. of Colleges reporting each function]			
Facilitates [23]	8	12	3
Supports [16]	7	8	1
Teaches [15]	4	8	3
Counsels [12]	1	10	1
Advises [11]	4	7	0
Liaises [11]	10	0	1
Monitors [9]	1	7	1
Supervises [9]	3	3	3
Guides [6]	0	5	1
Advocates [4]	0	4	0
Other** [17]	5	10	2
Totals [133]	43	74	16

* includes 4 role titles [3 reported once only; 1 (Lecturer/Practitioner reported x 3]

** includes 10 functions reported 3 times and less.

TIMETABLE

Dates	Activities
April - May 1991	Preliminary search of the substantive literature. Consideration of possible research strategies and data collection methods.
June - July 1991	Appoint Senior Research Fellow [EW]. Appoint Research Assistant [ER]. Agree modus operandi for Research Team. Recruit Steering Group. Preparatory interviews with experts. Examine all Project 2000 course submission documents held by the ENB. Draft research instruments. Identify data collection centres for pilot work and main study. Negotiate access. Seek approval from Ethical Committees.
July - October 1991	Develop, pre-test and pilot Stage 1 instruments. Preparatory meetings between Research Team members and prospective respondents in pilot and main study centres. Prepare Interim Statement for ENB.
November - February 1992	Main study [Stage 1] data collection. Transcribe and analyse interview data.
March - April 1992	Seek reapproval from Ethical Committees. Preparatory meetings between Research Team members and prospective respondents Develop, pre-test and pilot Stage 2 research instruments. Prepare 2nd Interim Statement for ENB.
May - August 1992	Main study [Stage 2] data collection.
September - November 1992	Analyse case study data.
December - March 1993	Write-up study and prepare final report. Draft text for publication in ENB Research Highlights series.

FRONTSHEET TO EACH INTERVIEW

[One to be completed for each STUDENT respondent]

(For office use only)

Date: ... ...

Interviewer: ...
[Initial]

Centre: ...
[Initial]

Branch: ...
[Initial]

Respondent: ....
[Code]

Sex: ...
[Initial]

Age: ...
[Prompt card code]

Ethnicity: ...
[Prompt card code]

Start date of course: ... ...

FRONTSHEET TO EACH INTERVIEW

[One to be completed for each QUALIFIED respondent]

(For office use only)

Date: ... ...

Interviewer: ...
[Initial]

Centre: ...
[Initial]

Branch: ...
[Initial]

Respondent: ....
[Code]

Sex: ...
[Initial]

Age: ...
[Prompt card code]

Ethnicity: ...
[Prompt card code]

Qualifications:

	Title	Where	When
Nursing [list]			
Other [list]			

Start date of course: ... ...

INTERVIEW SCHEDULE

[STUDENTS]

NB. Announce respondents code at the beginning of the tape-recording.

1. What qualifications did you bring to this course?

   [Prompt: Did you start straight from school?]

2. In general, how are you finding the course so far?

3. Briefly, how satisfied are you with
   : the CFP?
   : the Branch?

o-o-o0o-o-o

4. In the CFP, what sorts of practical experience did you have?

   [Prompt: How long in each?]

   [Prompt: Was any member of staff formally identified to help you learn in these practice areas?]

o-o-o0o-o-o

5. In the Branch, where have your practical placements been so far?

6. Would you tell me about some of the things you did, while you were in these practical placements?

7. Which people have helped you with your learning in practical placements?

   [Prompt: Would you describe how they did so?]

8. Has any member of staff been **formally** identified to help you learn in these practical placement areas?

9. What is their role?

   [Prompt: What do you call this person? *** for Q11]

10. Are their any differences between your experience of learning in the practical placement areas of the CFP, compared with the Branch?

11. How many *** are identified for you for each practical placement?

[Prompt: Is this the same for each placement?]

12. Can you give me an idea of the time you are attached to each ****?

[Prompt: How much contact time do you have during this time?]

13. What are the good and bad things about your ****?

14. Have all your **** been first level nurses [RGNs/RMNs], or have they included Enrolled Nurses and/or staff in other occupations?

o-o-o0o-o-o

15. Turning now to your tutorial staff, have you been visited by anybody from the School/College of Nursing during the course?

[Prompt: Were these visits pre-arranged?]

[Prompt: What did they actually do when they visited?]

16. Do you have learning objectives for each practical placement areas?

[Prompt: How realistic is it to achieve these within the time and experience available?]

17. Is there a separate person who is responsible for assessing your practice?

[Prompt: Would you describe your experience of having your practice assessed?]

[Prompt: To what extent did you participate in having your practice assessed?]

[Prompt: Is there an opportunity to give feedback about your practical experience to the qualified staff in the placement area?]

o-o-o0o-o-o

18. Do you consider yourself to be supernumery in practical placement areas?

    [Prompt: What does 'supernumery' mean in practice?]

    [Prompt: What are you expected to do and not to do?]

    [Prompt: Do you ever wear a uniform in practical placement areas? Does this make a difference to your experience of being supernumery?]

19. Has your experience in the practical placement areas so far, met your expectations?

20. Under the current arrangements, how easy is it for P2K students to use what you are learning in your College, in the practical placement areas?

21. Could anything be different which would improve the nature of your learning experience in the practical placement areas?

22. Can you identify anyone who has particularly inspired you in the practical placement areas, or who has provided you with a really good role model?

    [Prompts: Why? Has your practice changed as a result?]

23. Would you name for me 3 practical placement areas which have provided you with the best learning experiences so far?

    [Prompt: What was it about them which made them so good?]

24. What are the best and worst things about being a Project 2000 student? [Critical Incidents]

25. And finally, is there anything else you would like to add about your experience of learning in practical placement areas, which we have not covered during this interview?

THANK YOU

INTERVIEW SCHEDULE

[QUALIFIED STAFF]

NB. Announce respondents code at the beginning of the tape-recording.

1. What are your present job responsibilities?

2. How long have you been in your present post? [Years/months]

3. Would you tell me about your previous work experience before taking up your present post?

4. PRACTITIONERS ONLY:
Would you tell me about the area in which you work?

OR

4a. TUTORIAL STAFF ONLY:
Do you have responsibility for a specific clinical area[s]? [Identify it/them]

[Prompt: If yes, what are these responsibilities?

[Prompt: If no, What contact do you have with the students practical placement areas?

Are you satisfied with this arrangement? If not, why not?

5. Do you have a role in helping P2K students learn in practical placement areas?

[Prompt: If yes, what is the title of this role?]

[Prompt: What do you actually do with students to help the learn?]

[Prompt: What other types of students do you have responsibility for? HCAs?

6. PRACTITIONERS ONLY:
How long have you been performing this role?

OR

6a. TUTORIAL STAFF ONLY:
How long have you been working in these areas?

7. How were you chosen for this role? [Voluntary choice?]

8. Do you have any responsibility for assessing P2K students in their practical placement areas?

   [Prompt: Do you feel this is appropriate?]

   [Prompt: What does this actually involve?]

9. Are you familiar with the learning objectives for Project 2000 students in their practical placement areas?

10. Have P2K students been able to meet these learning objectives?

    [Prompt: If not, why not?]

11. Is what you do now to help P2K students learn, different from your work with 'traditional' students?

    [Prompt: If different, how?]

12. How have you been prepared for your role[s]?

    [Prompt: Did you have any specific training to prepare you for work with P2K students in practical placement areas? ENB998? Other?]

13. Would you say how adequate your own preparation has been?

    [Prompt: Explore any possible areas of shortfall]

14. Who else, other than you, is involved in helping P2K students to learn in practical placement areas?

    [Prompt: What is it that you do, that they don't?]

    [Prompt: Would you describe your relationship with them?]

    [Prompt: How does your role link with theirs?]

15. What preparation have these others had to help P2K students learn in their practical placement areas?

    [Prompt: How adequate has this been, in your view?]

16. Are the needs of P2K students in practical placement areas different from the needs of 'traditional' students?

    [Prompt: If different, how?]

17. Have you found the P2K students, themselves, different from traditional students?

    [Prompt: If different, how?]

18. Under the current arrangements, how easy is it for P2K students to use what they are learning in college, in their practical placement areas?

19. Would you say that you experience so far of helping P2K students to learn in practical placement areas, is what you expected?

    [Prompt: What did you expect?]

    [Prompt: How does it differ?]

20. What is it that you do with P2K students that works well in the practical placement areas?

    [Prompt: Viz, helps them to learn]

21. Is there anything about the present arrangements in practical placement areas that you would like to change?

22. And finally, would you name for me 3 practical placement areas, on the training circuit, which provide P2K students with the best learning experiences?

    [Prompt: What is it about them which makes them so good?]

THANK YOU

Fragment of verbatim transcript between the interviewer [EW] and a tutor.

Interviewer: So; do you have responsibilities for assessing project 2000 students in clinical areas?

Respondent: No, I haven't. I have taken part in discussion when the mentors were looking at the first assessment. Because they were just starting the mental health branch; there was a new assessment tool; we used Bondy, well, its an adapted version of the Bondy tool. And was fairly....just sort of, helping the student to self-assess themselves. Well where I am in this particular thing? For example, there were things like in the communication skills, which was broken down into several sectors and basically help them to reflect, and to see where they're at, and at what point they are in that particular skill. Because there are five levels, from independent to dependent. So its really sort of helping them to sort out at what level....but the final assessment, no, I have'nt been involved.

Interviewer: Right. So; if you don't do it, who does?

Respondent: Well, they have a mentor, a chosen mentor, on the ward, who the bulk of the time they'll be working with. So that their supervisor will have a pretty good idea about where they're at, at this particular time.

Interviewer: Two things, there. First, you said that they were chosen, what do you mean by that? Do you mean that students choose their mentor, or are they simply allocated?

Respondent: They're allocated, yes.

Interviewer: Second thing you said was 'supervisor'.

Respondent: Right.

Interviewer: Did you mean 'supervisor', or 'mentor'?

Respondent: Mentor.

Interviewer: I just wondered if there was another group of people called 'supervisors'.

Respondent: No. No, the same person who is the mentor, but also supervisor. And also could be an assessor [laughs].

Interviewer: Right, we'll unpack it as we go along.

Respondent: Right.

Interviewer: So, you don't have a formal role in assessing project 2000 students.

Respondent: No.

Interviewer: Right. Is this an appropriate state of affairs, do you think?

Respondent: Er, I think so. Because I think it would be unfair for me to go on the wards and having, not worked for a length of time with the student, to be there and just to go in and assess them, I don't think its fair. I think one needs to be working with them for a good length of time, before one can actually, honestly assess them.

Figure to show the Case Study design, which comprised six case studies [three each in the Adult and Mental Health Branches] and involved eighteen settings [nine each Branch]. The balance between hospital and community settings, was to approximate the orientation of service delivery for each Branch.

CENTRE	ADULT	MENTAL HEALTH
A	Hospital Hospital Community	Community Community Hospital
B	Hospital Hospital Community	Community Community Hospital
C	Hospital Hospital Community	Community Community Hospital

CASE STUDY

SETTING

Observation Protocol

Observation to take place for the majority of a whole work shift. [At least one hour required at the end of the shift for debriefing interviews.] Shifts chosen for observation to be both early, or late shifts.

During observation, researcher to focus on one Project 2000 student and so to follow him/her, even if their time is not spent with allocated staff].

Observation to start at the begining of the shift. Researchers to take field notes during the handover and at the end of this, to inquire whether there are any pre-arranged teaching/learning events [predictable events*] which will involve the student, to take place during the shift. If so, researcher to make arrangements to be present during these and tape record them, if possible.

Examples of predictable events;

- tutorial visits
- reflection/teaching with mentor
- formal teaching sessions
- specific learning opportunities requested by student or arranged by staff

Following handover, researcher to gain consent from any patients who may be involved in the study.

At least three periods of tape recording to be made during each shift:

i immediately following report for approx 45mins.
ii at least one predictable event* for approx 45 mins.
iii towards the end of the shift for approx 45 mins aiming to record the student and practitioner evaluating the care given during the shift. [An appropriate time for this may be if the student and staff complete any documentation together].

Student to wear a lapel microphone and carry the tape recorder around in their pocket, if possible. Researchers to note the time when this is commenced, in order to judge when the tape will run out.

At all times during the observation [whether taping, or not] field notes to be made recording the students activities and interactions with other staff, that appear to be important with regard to teaching and learning. The time and location should be noted at the start of each entry and include a record of people involved. It should also be noted whether the event is being taped and if so a note of which side of which tape.

The selection of incidents to be noted will be determined by the researchers. The following list of staff/student activities are to be used as a guide of what constitutes a potentially interesting event to record;

- liaising with tutors
- working with students
- supporting students
- teaching about illness
- teaching about patients [individually or in groups]
- evaluating the shift
- setting objectives
- structuring the students experience
- planning programmes
- allocating patients through discussion
- teaching by example
- talking students through experiences

AIDE MEMOIRE FOR EXTENDED INTERVIEW

Themes should, if possible, be developed with the respondents concerned at the time of the debriefing interviews. If this is not possible, or if the respondent has not been involved in the observation period, then another time should be arranged after the observation has been completed.

The following people should be included in this;

* The observed student
* The observed practitioner
* The tutor involved in the setting

  The sister/charge nurse [if a ward setting].
  Second/third mentor, if the student has more than one.
  Students assessor [if separate from the mentor and not included in the above].

[* definite respondents; ie there should be a minimum of 3 extended interviews per setting per branch]

1. Tutor/ward team [practitioner] power relationship?
   -what does it involve?
   -has this changed over time?

2. Practitioner preparation for teaching students?

3. Supernumerary status?

4. Theory/practice linkage?

5. Level of assessment?
   -what does it mean?
   -has anything changed?
   -is anything different?

6. Nature of the student/supervisor relationship?
   -how important is this and why?
   -who is it that the student has learnt most from in the placement?

7. The stresses involved in supervision?
   -for the student.
   -for the practitioner.

8. Feedback/evaluation of the setting/placement?
   -particularly the students experience of

9. What do you do that works well for the students learning?
   What would you like to change?

AIDE MEMOIRE FOR DEBRIEFING INTERVIEW

Interview to take place following complete period of observation and expected to last approimately 15 mins. Definitely interview student [and the practitioner to whom they had been allocated to work during the period of observation]. If practical, also interview all other staff/students who seem to have been important in the students learning during the observation period. This is to be done before those involved go off-duty.

Question areas for students:

Contextual information required.

i Start date of course
ii Branch
iii Age
iv. Length of time in present placement

v. Were they allocated to work with a specific member of staff on the shift observed?
- was this someone who had formal responsibility for them for the duration of the placement?
- have they worked with this staff before?

vi Did they spend much time working with their allocated member of staff?
- were there specific reasons for this?

vii Were they allocated patients on this shift?
- how many?
- did they have a choice in this?
- is this usual for them in this placement?

1 What was the best thing that happened today that helped you to learn?

2 What was the worst thing that happened today that made your learning difficult?

3 Was this a usual type of day for you in this placement in relation to your learning needs?

Question areas for practitioners:

Contextual information required.

i Grade and job title
ii Qualifications
iii Specific job responsibilities

iv How long have they been working in this ward/setting?

v Do they have formal responsibility for any students learning in the ward at present
- did they have any choice in this?
- have they recieved any specific training/preparation for this?

vi Were there specific responsibilities which prevented them from spending as much time as they would have liked to with this student today? eg being in charge of the ward, having responsibility for another learner also, having to escort a patient.

1 What was the most important thing you did today to help the student learn?

2 Did anything happen that was a barrier to the students learning?

3 Was this a usual type of day for you? If not, what was unusual about it?

CONTEXTUAL DETAILS

Ward profile:

Number of beds
-Number and type of specialities
-Number of consultants
-Number of staff and skill mix
 ·whether up to establishment

-Patients
 · gender
 · average length of stay

-Ward layout

-Ward facilities - day rooms/bathrooms/teaching rooms/offices
 ·are they considered adequate?
 ·what are they used for?

-Educational resources
[a] books/journals/teaching packs/models]
 ·what is available?
 ·where are these kept?
 ·who has access to them?

[b] does the ward have any formal educational programme?
 ·if yes, describe it
 ·who is responsible for this?
 ·who takes part in it?

[c] other teaching resources available? eg personnel

[d] are there any other formal teaching/learning opportunities within the hospital in which the student may participate? [eg unit teaching sessions/research interest groups/journal clubs]
 ·if yes describe and give some indication of participation

-Collect any relevant documentation [eg, ward philosophy/ ward learning objectives/student orientation information

-Ward organisation
 ·normal system of student allocation
 ·organisation of care
 ·does the ward use a model of nursing?

-Anything else felt to be relevant

Community profile:

-Location
- urban
- rural
- inner city
- other

-Type of practice setting
- primary health care team
- health authority clinic
- health centre
- general practitioner surgery
- family centre
- hospital
- other

-Do practitioners have acccess to an age/sex register?
- is any infomation routinely gathered concerning practitioners client groups? If yes, who collects this?
- is it made available to practitioners?

-Organisation of work
- attached to GP practice
- aligned to GP practice
- geographic practice
- shared caseload
- other

-Physical environment for practitioner
- office; single occupancy, multi occupancy?
- desk and chair for student
  secure storage for records
- access to telephone and message retrieval
- clerical help
- computer system; access to this?
- room for counselling/teaching students
- room for teaching/health education activities
- staff room
- special accomodation for health clinics/groups

-Support services
i. health education resources
ii. aids and equipment
iii. CSSD

-Meetings and liaison with other disciplines and agencies
- who attends?

-Meetings with other members of the PHCT. Who organises them?
- who attends? [eg HV, DN, Midwife, CPN, Community Mental Handicap Nurse, School Nurse, Practice Nurse, Family Planning Nurse, GP's, Social Workers]
- meetings with other agencies [specify]
- some indication of staff use, deployment and skill mix

-Learning opportunities for students
  - books/journals/teaching resources
  - what is available and where are they kept?
  - who has access to them?
  - are there any organised teaching/learning opportunities which the student/practitioner may attend? eg research interest groups/journal clubs.
  - how often are they and what is the nature of their participation?
  - are there opportunities for shared learning with own and other disciplines?

-Collect any relevant documentation eg student learning objectives, student learning packs

-Anything else which seems relevant [eg proposed changes]

Table to show the characteristics of the Student respondent group, drawn for Stage 1 Adult interviews.

STUDENTS [n=30]

Respondent	Sex	Age	Ethnicity	Qualifications
AAER13	M	A	A	10 O levels
AAER14	M	D	A	3 A levels
AAER15	F	A	A	2 A levels
AAER16	F	A	A	7 O levels
AAER17	M	B	A	Degree
AAER18	F	B	A	5 O levels
AAER19	F	A	A	2 A levels
AAER20	M	A	E	10 O levels
AAER21	F	A	A	6 O levels
AAER22	F	A	A	7 O levels
BAER20	F	A	A	2 O/A levels
BAER22	F	D	A	5 O levels
BAER23	F	D	A	4 A levels
BAER24	F	E	A	Degree
BAER25	F	A	A	4 A levels
BAER28	F	A	A	7 O levels
BAER4	F	A	A	1 A level
B[W]AER1	F	A	A	2 A levels
B[W]AER2	M	A	A	6 O levels
B[W]AER3	F	A	A	3 A levels
CAER13	M	B	A	7 O levels
CAER14	M	A	A	5 O levels
CAER15	F	A	A	7 O levels
CAER16	F	A	A	2 A levels
CAER17	F	A	A	5 O levels
CAER18	F	C	E	Degree
CAER19	M	B	A	3 A levels
CAER20	F	A	A	1 A level
CAER21	M	C	A	8 O levels
CAER22	F	A	A	2 A levels

Legend:

Sex	M Male F Female
Age	A 18-23 B 24-29 C 30-34 D 35-39 E 40-44
Ethnicity	A White E Indian
Qualifications	Highest gained

Summaries:

Centre	Sex		Age					Ethnicity	
	M	F	18-23	24-29	30-34	35-39	40-44	White	Other
A	4	6	7	2	0	1	0	9	1
B	1	9	7	0	0	2	1	10	0
C	4	6	6	2	2	0	0	9	1

Centre	'O' level	'A' level	Degree
A	6	3	1
B	4	5	1
C	5	4	1

Tables to show summary characteristics of the Practitioner and Tutor respondent groups, drawn for Stage 1 Adult interviews.

PRACTITIONERS [n=17]

Centre	Sex		Age						Ethnicity	
	M	F	24-29	30-34	35-39	40-44	55-59	Missing	White	Other
A	1	5	2	0	2	1	1	0	6	0
B	0	6	1	3	1	1	0	0	6	0
C	0	5	1	1	0	1	0	2	5	0

TUTORS [n=17]

Centre	Sex		Age						Ethnicity	
	M	F	24-29	35-39	40-44	45-50	50-54	Missing	White	Other
A	1	4	0	1	0	3	1	0	5	0
B	0	6	1	1	2	1	1	0	6	0
C	1	5	0	1	1	0	0	4	5	1

Legend:

Sex M Male F Female

Table to show the characteristics of the Student respondent group, drawn for Stage 1 Mental Health interviews.

STUDENTS [n=23]

Respondent	Sex	Age	Ethnicity	Qualifications
BMEW1	F	A	A	6 O levels
BMEW2	M	C	A	3 CSEs [+DC]
BMEW3	F	A	A	6 O levels
BMEW4	M	A	A	5 O levels [+DC]
BMEW6	M	B	A	2 A levels
BMEW7	M	B	A	1 A level
BMEW8	M	B	A	6 O levels
BMEW9	F	B	I	3 A levels
BMEW15	M	B	A	2 A level
EWLMH2	F	B	A	8 O levels
EWLMH3	M	B	A	10 O levels
EWLMH4	M	B	A	4 O levels [+DC]
EWLMH5	M	E	I	Diploma Eqivalent
EWLMH8	F	C	B	6 O levels
EWLMH9	F	A	A	2 A levels
EWLMH10	M	C	A	3 O levels [+DC]
EWLMH15	M	B	A	2 O levels [+DC]
EWBMH7	M	C	A	5 O levels
EWBMH8	M	B	A	Degree
EWBMH9	M	B	A	Degree
EWBMH10	F	B	A	Degree
EWBMH11	M	D	A	Degree
EWBMH12	M	B	A	Degree

Legend:

Sex	M Male F Female
Age	A 18-23 B 24-29 C 30-34 D 35-39 E 40-44
Ethnicity	A White B Black Caribbean I Other
Qualifications	Highest gained

Summaries:

Centre	Sex		Age					Ethnicity	
	M	F	18-23	24-29	30-34	35-39	40-44	White	Other
A	6	3	3	5	1	0	0	8	1
B	5	1	0	4	1	1	0	6	0
C	5	3	1	4	2	1	0	6	2

Centre	'O' level	'A' level	Degree
A	5	4	0
B	1	0	5
C	6	2	0

Table to show the characteristics of the Practitioner respondent group, drawn for Stage 1 Mental Health interviews.

PRACTITIONERS [n=20]

Respondent	Sex	Age	Ethnicity	Qualifications
BMEW10	F	D	A	1,*
BMEW11	F	E	A	1,2,3
BMEW12	F	B	A	1,4,D
BMEW13	F	B	I	1,4
BMEW16	F	E	E	1,3
BMEW17	F	E	A	1,**,D
BMEW18	M	B	A	1
EWLMH1	F	D	D	1,2,4,5,6
EWLMH6	M	D	H	1,4,6
EWLMH7	F	C	A	1,4,6
EWLMH11	M	E	E	1,2,4,6
EWLMH13	F	E	A	1,2,4,5,6
EWLMH14	F	C	A	1,2,4
EWLMH16	M	E	A	1
EWBMH2	M	B	A	1,D
EWBMH4	M	C	A	1
EWBMH5	M	C	A	1,D
EWBMH6	F	B	A	5
EWBMH14	F	C	A	1,4,7,*
EWBMH15	M	C	A	1,4,8

Legend:

Sex	M Male F Female
Age	A 18-23 B 24-29 C 30-34 D 35-39 E 40-44
Ethnicity	A White B Black Caribbean D Black[other] E Indian H Chinese I Other
Qualifications	1 RMN 2 SRN/RGN 3 C&G 730 4 ENB 997/998 5 SEN[M] 6 DipCPN 7 ENB 941 8 ENB 939 * Other D Degree

Summary:

Centre	Sex		Age				Ethnicity	
	M	F	24-29	30-34	35-39	40-44	White	Other
A	1	6	3	0	1	3	5	2
B	4	2	2	4	0	0	6	0
C	3	4	0	2	2	3	4	3

Table to show the characteristics of the Tutor respondent group, drawn for Stage 1 Mental Health interviews.

TUTORS [N=8]

Respondent	Sex	Age	Ethnicity	Qualifications
BMEW5	M	E	I	1,2,6,9
BMEW14	F	D	I	1,2,10,11
BMEW19	M	F	I	1,9,12,13
EWLMH12	M	F	B	1,2,6,9,14,D
EWLMH17	M	D	A	1,2,6,9,D
EWBMH1	M	D	A	1,2,10,15,16
EWBMH3	M	G	A	1,9,16
EWBMH13	M	D	A	1,2,9,10

Legend:

Sex	M Male F Female
Age	A 18-23 B 24-29 C 30-34 D 35-39 E 40-44 F 45-49 G 50-54
Ethnicity	A White B Black Caribbean D Black[other] E Indian H Chinese I Other
Qualifications	1 RMN 2 SRN/RGN 3 C&G 730 4 ENB 997/998 5 SEN[M] 6 DipCPN 7 ENB 941 8 ENB 939 9 Cert Ed 10 Dip Nursing 11 PGCEA 12 Health Ed Cert 13 FETC 14 ENB953 15 Dip N Ed 16 RCNT * Other D Degree

Summary:

Centre	Sex		Age					Ethnicity	
	M	F	30-34	35-39	40-44	45-49	50-54	White	Other
A	2	1	0	1	1	1	0	0	3
B	3	0	0	2	0	0	1	3	0
C	2	0	0	1	0	1	0	1	1